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U. S.
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Welfare
Administration

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Welfare Administration

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WELFARE in REVIEW

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U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

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Welfare Provisions of the 1965 Social Security Amendments

A Brief Guide for State Action

MEDICAL CARE FOR NEEDY PEOPLE

The most far-reaching provisions of this new legislation are those designed to bring the benefits of modern health and medical care to all needy people. The law does this by authorizing Federal aid to States to enable them, at their option, to take the following actions:

1. Pay the "deductibles" for aged persons who cannot afford to pay for the deductible items in the hospital insurance program administered by the Social Security Administration.

Beginning July 1, 1966, all persons over 65, whether or not they receive social security payments, will be automatically covered by the hospital insurance provisions of the 1965 Social Security Amendments. This will mean a tremendous saving in public assistance funds now being spent for hospital and nursing home care and home health services--savings that can help to finance a broadened medical care program for the needy. It is expected that public welfare agencies will pay the deductible items for elderly persons who qualify for old-age assistance and medical assistance for the aged and, if they adopt the new medical assistance program, described under item 3 below, the payment of these deductibles for all elderly people who are included in the program is mandatory.

2. See that all elderly people who receive public assistance grants obtain the benefits of the voluntary medical insurance program administered by the Social Security Administration.

In addition to paying for the deductible items of this insurance, arrangements can be made to pay the monthly premiums. There are various methods of handling the premiums. If the elderly person is receiving part of his income from social security benefits, he must have the insurance premium taken out of his monthly OASDI check, but his public assistance payment can be increased by $3 a month so that his total income will remain the same. If the elderly person receives old-age assistance payments, the State can either pay the premium directly to the insurance carrier or increase the individual's monthly payment so that he can pay the premium himself.

3. Start a new medical assistance program that would ultimately include most of the medically indigent in the State. This program can be developed in stages.

First priority must go to persons who are receiving financial assistance under the federally aided public assistance programs. After all these groups are included, States can extend the program to persons of any age who, except for their income and resources, would be eligible for financial assistance under any one of the federally aided public assistance programs and to any child under 21 whose family cannot pay for the medical care he needs.

Under the new program (Title XIX of the Social Security Amendments), the medical care available to all persons whom it includes, irrespective of age or type of disability, must be equal in amount, duration, and scope. There are just two exceptions to this requirement: the programs for children need not include nursing home care, and provisions for aged persons in mental and tuberculosis institutions do not require the program to include care in these institutions for persons under

65. The amount and scope of the benefits for the medically indigent can be no greater than those provided for persons receiving money payments.

No length of residence requirement can be set for people who are included in the program, and the only relatives who can be required to contribute are a spouse or the parents of a minor child or a disabled child of any age.

Effective Dates

The new program will go into effect, on an optional basis with the States, on January 1, 1966. If States are to continue medical vendor payments for recipients of public assistance or medical assistance for the aged, they will need to convert from their existing programs to the new program by January 1, 1970, for the law now provides that Federal sharing in the costs of aid in the form of medical or other remedial care will terminate under present programs as of that date.

Services Required

States coming into the new program before July 1, 1967, must provide some institutional and some noninstitutional care for all recipients. However, after June 30, 1967, a State adopting the Title XIX program must provide inpatient hospital services, outpatient hospital services, other laboratory and X-ray services, skilled nursing home services for persons over 21 years of age, and physicians' services (whether furnished in the office, the patient's home, a hospital, a skilled nursing home, or elsewhere). Because of the administrative changes necessary to embark on a sizable new program, States are being encouraged to provide the five required services from the inception of their Title XIX programs.

In their plans, States will be expected to approach the provision of such medical care services with the explicit constructive aim of making them readily available to all eligible persons. The States are expected, furthermore, to set standards that will be appropriate to insure that the services will be of high quality and to adopt simplified methods of administration designed to assure that the services are furnished in a sympathetic and dignified manner. The goals of medical care services for the needy and the medically indigent must be spelled out in the State plan.

Although the law requires priority consideration for recipients of money payments, there must be a commitment to progressive program expansion to cover individuals who would, except for income and resources, be eligible for money payments, then children in low-income families, and, by July 1, 1975, substantially all medically indigent individuals should be eligible for some medical care program, with State and local funds supporting care for those who cannot be included in the federally aided program.

As presently conceived, Federal implementing material for the new program will relate to State medical care units, advisory committees, scope of services, standards for medical care, and methods for assuring that those who are eligible and need medical services will obtain them.

The scope of the services offered should be designed to minimize the use of expensive inpatient facilities, to promote appropriate and continuous care for all who require it, and to provide as well-rounded and comprehensive a service as possible.

Title XIX requires "physician services, whether furnished in the office, the patient's home, a hospital, or a skilled nursing home or elsewhere." To comply with this and similar provisions, States will need to establish a realistic schedule of compensation for all services, preferably commensurate with "reasonable cost" or "reasonable charge" and consistent with prevailing community payments. The law requires that hospitals be paid on a "reasonable cost" basis by July 1, 1967.

State Planning

With the emphasis on quality of care in the new program, it becomes increasingly evident that individual States will need to weigh carefully when they are ready to move into the program. The financial attractions are only one element. For most States the new program will

require substantial upgrading in scope and quality of services. For a number of them, therefore, there may be an intermediate period during which every effort should be made to strengthen existing vendor payment programs under public assistance and medical assistance. Some States will need new State legislation; policy changes will almost certainly be required; fiscal capacities will be another factor in the variation in State progress. It is important that States assess all these as well as a number of other highly complex administrative factors promptly so that they can begin to make realistic plans.

For a State to try to undertake the new program without adequate professional and financial resources will mean frustration in efforts to meet the plan requirements and corruption of the intent of the Congress in enacting such progressive legislation.

Increased Federal Matching Funds

The Federal share of medical assistance expenditures under the new program is determined upon a uniform formula with no maximum on the amount of expenditures which are subject to participation. This currently is done for the medical assistance for the aged program. The Federal share, which varies in relation to a State's per capita income, is increased over current medical assistance for the aged matching so that States at the national average receive 55 percent rather than 50 percent, and States at the lowest level receive as much as 83 percent as contrasted with 80 percent under existing law.

In order to receive any additional Federal funds as a result of expenditures under the new program, the States need to continue their own expenditures for all welfare programs combined at their present rate. For a specified period, no State would receive less in Federal funds than under current provisions of law because of the new formula and any State that did not reduce its own expenditures would be assured of at least a 5-percent increase in Federal participation in medical care expenditures. As for compensation and training of professional medical personnel, the law provides a 75-percent Federal share as compared with the 50-50 Federal-State sharing for other administrative expenses.

Administration

The program can be administered by any State agency established or designated for the purpose, but the law requires that eligibility be determined by the public welfare agency. The bill specifically provides, as a State plan requirement, that cooperative agreements be entered into with State agencies providing health services and vocational rehabilitation services looking toward maximum utilization of these services in the provision of medical assistance under the plan.

OTHER IMPROVEMENTS IN PUBLIC ASSISTANCE PROGRAMS

The new law attacks one of the most fundamental problems in the public assistance programs--the low payments which tend to lock people into a life of extreme deprivation with little hope of escape. It does this in the following ways:

Work Incentives

The Federal requirement that all income be taken into account in determining the monthly payment has been liberalized. States can now get Federal funds for payments made in the aid to families with dependent children, aid to the permanently and totally disabled, and old-age assistance programs which do not take account of some of the earnings of recipients.

Up to $50 a month earned by a child under 18 in an AFDC family (but not more than $150 of total earnings by children in the same family) can be disregarded in determining the monthly payment.

Persons receiving old-age assistance or aid to the permanently and totally disabled can earn up to $50 (the first $20 and half of the next $60) without having their payments reduced. Formerly the maximum amount of monthly earnings they

could keep as additional income was $30. Aid to the blind provisions on earnings were not changed as they allow the blind to keep whatever income and resources are deemed needed to carry out an approved rehabilitation plan. States, if they wish to do so, can now apply this same type of exemption to recipients in the APTD program.

Higher Payments

The Federal share of payments under all State public assistance programs is increased a little more than a national average of $2.50 a month for the needy aged, blind, and disabled and an average of about $1.25 for needy children, effective January 1, 1966. This is brought about by revising the matching formula for the needy aged, blind, and disabled (and for the adult categories in Title XVI) to provide a Federal share of $31 out of the first $37 (now twenty-nine thirty-fifths of the first $35) up to a maximum of $75 (now $70) per month per individual on an average basis. The matching formula for aid to families with dependent children is revised so as to provide a Federal share of five-sixths of the first $18 (now fourteen-seventeenths of the first $17) up to a maximum of $32 (now $30). A provision is included so that States will not receive additional Federal funds except to the extent they pass them on to individual recipients or use them in other ways to improve the programs, not to reduce the States' share of the cost. Effective January 1, 1966, funds available through these amendments and savings resulting from medicare provisions for the aged offer States the opportunity of improving substandard assistance payments and simplifying methods of determining need at no additional cost in State funds.

"Windfall" Benefits

Changes in the Federal requirements also make it possible for States to disregard the lump sum of social security benefits--representing a 7-percent increase in their monthly benefit payment from January 1965 to September 1965--that old-age insurance beneficiaries will receive without reducing the public assistance payment to take account of this additional income. In addition, $5 a month of any income can be disregarded in computing the amount of public assistance a person is eligible to receive.

Payments for Students

A 1964 amendment made it possible for States to use Federal funds in payments, under the aid to families with dependent children program, that covered family members aged 18 to 21 if they were attending high school or taking vocational training. The new amendment broadens this to include students aged 18 to 21 who are attending a college or university.

Aid for Tuberculous and Mental Patients in Institutions

The bill removes the exclusion from Federal matching in old-age assistance and medical assistance for the aged programs (and for the combined program, Title XVI) as to aged individuals who are patients in institutions for tuberculosis or mental diseases or who have been diagnosed as having tuberculosis or psychosis and, as a result, are patients in a medical institution. It requires as a condition of Federal participation in such payments to or for aged patients in mental institutions certain agreements and arrangements to assure that better care results from the additional Federal money. It provides that States will receive no more in Federal funds under this provision than they increase their expenditures for mental health purposes under public health and public welfare programs. Also it removes restrictions as to Federal matching for needy blind and disabled who are tuberculous or psychotic and are in general medical institutions.

Protective Payments to Third Persons

The bill adds a provision for protective payments to third persons on behalf of recipients of old-age assistance, aid to

the blind, aid to the permanently and totally disabled (and recipients on combined Title XVI program) unable to manage their money because of physical or mental incapacity. Effective January 1, 1966.

Definition of Medical Assistance for Aged

The bill modifies the definition of medical assistance for the aged so as to allow Federal sharing in both MAA and old-age assistance for the month in which recipients are admitted to or discharged from a medical institution. Effective July 1, 1965.

Alternative Formula for Federal Participation

Any State, at its option, after adopting Title XIX (medical assistance) may claim Federal participation in its money payments under the same formula provided under Title XIX instead of under the different formulas in the other public assistance titles. This offers potential for substantial administrative simplification.

SPECIAL PROGRAMS FOR CHILDREN

The provisions in the new law which relate specifically to children are almost as far-reaching in their potential benefits to the oncoming generations as are the insurance provisions for the elderly. In addition to the new medical assistance program which should, within 10 years at most, assure high-quality preventive, curative, and remedial care to all medically needy children, there are additional provisions for child health and child welfare. These are the major ones:

Maternal and Child Health, Crippled Children, and Child Welfare Services

The law increased the amount authorized for maternal and child health services over previous authorizations by $5 million for fiscal year 1966 and by $10 million in each succeeding fiscal year, as follows:

Fiscal year	Previous law	Public Law 89-97
1966	$40,000,000	$45,000,000
1967	40,000,000	50,000,000
1968	45,000,000	55,000,000
1969	45,000,000	55,000,000
1970 and after	50,000,000	60,000,000

The authorizations for crippled children's services and child welfare services are increased to the same amounts. Such increases will assist the States, in all these programs, in moving toward the goal of extending services with a view to making them available to children in all parts of the State by July 1, 1975.

Crippled Children--Training Personnel

The law also authorizes $5 million for the fiscal year 1967, $10 million for fiscal 1968, and $17.5 million for each succeeding fiscal year for grants to institutions of higher learning for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps.

Health Care for Needy Children

A new provision is added authorizing the Secretary of Health, Education, and Welfare to carry out a 5-year program of special project grants to provide comprehensive health care and services for children of school age, or for preschool children, particularly in areas with concentrations of low-income families. The grants are to State health agencies, to the State agencies administering the crippled children's program, to any school of medicine (with appropriate participation by a school of dentistry), and any teaching hospital affiliated with such school, to pay not to exceed 75 percent of the cost of the project. Projects will provide screening, diagnosis, preventive services, treatment, correction of defects, and aftercare, including dental services, for children in low-income families.

An appropriation of $15 million is authorized for the fiscal year ending June 30, 1966; $35 million for the fiscal year ending June 30, 1967; $40 million for the fiscal year ending June 30, 1968; $45 million for the fiscal year ending June 30, 1969; and $50 million for the fiscal year ending June 30, 1970.

Timetable for Implementation of the Welfare Provisions of the 1965 Social Security Amendments*

JULY 1, 1965

The following provisions, all optional with the States, became effective:

Children under 18 in families receiving aid to families with dependent children grants can earn up to $50 a month (with a maximum of $150 for earnings of children in one family) without having public assistance payments reduced.

Young people aged 18 to 21 can be included in payments made under the aid to families with dependent children program if they are attending a college or university. Formerly, this extension was limited to young people in high school or taking vocational training.

Federal funds under both the old-age assistance and the medical assistance for the aged programs can be used on behalf of an aged person during the month when he is either admitted to or discharged from a medical institution. Previously, the Federal government could not share in the payment for MAA services rendered during a month when an elderly person also received an old-age assistance grant. This meant that a recipient who was in an institution only part of a month had to have the entire cost of his institutional care paid from State or local funds.

SEPTEMBER 1965

This is the month when beneficiaries of the old-age, survivors, and disability insurance program are scheduled to receive a lump sum representing a 7 percent increase in benefits retroactive from January 1, 1965. States can disregard this entire sum in determining the monthly payments for recipients of public assistance who are also receiving this social security benefit.

Some disabled and aged persons, as well as children of deceased workers who are between 18 and 22 years of age, will become newly eligible for social security insurance payments. For those who have been dependent on public assistance, some adjustment in their public assistance grants may be called for. (First OASDI payments will arrive in October.)

*This timetable does not cover the increased authorizations for maternal and child health, crippled children, and child welfare programs or the grants authorized for health projects for school and preschool children and for training of medical and ancillary personnel who work with children. All of those provisions become effective on the date appropriations are made under the new authorizations.

September 1 is the earliest date that States can enter into an agreement with the Secretary of Health, Education, and Welfare which will permit them to arrange for all persons over age 65 who are dependent on public assistance (except those who also receive social security insurance) to be covered under the voluntary medical insurance program of the Social Security Administration.

OCTOBER 1, 1965

All persons receiving public assistance payments can retain $5 a month income from any source--job, social security benefit, relatives, etc.--without any reduction in public assistance payment. (Action optional with States.)

Aged and disabled persons who are receiving public assistance can keep up to $50 a month of earnings (the first $20 of earnings plus half of the next $60) without having their public assistance payments reduced. (Action optional with States.)

JANUARY 1, 1966

This is the earliest date that States can take advantage of the following major provisions:

States can set up a new medical assistance program to replace and liberalize the medical care now being given under their public assistance and medical assistance to the aged programs, with the Federal government paying from 50 to 83 percent of the cost.

As soon as States have adopted the new medical assistance program, they can also apply the formula for Federal matching funds which is used in this new program to their money payments under all of the public assistance programs. Some, but not all, States will find it to their advantage to shift to the new formula.

The Federal share of the cost of the old-age assistance, aid to the blind, aid to the permanently and totally disabled, and aid to families with dependent children programs will be increased enough to add, on a national average, about $2.50 a month to the grants in the adult programs and $1.25 a month for each person in a family receiving AFDC. States can get this additional money only if they pass it on to recipients or otherwise improve their programs. It cannot be used to reduce the State's share of the cost.

This is also the effective date of a provision which conditions all the additional aid to States

which is authorized by the new legislation, namely: if a State has reduced its total State and local expenditures for public assistance from a base period (State public welfare agencies are aware of their base period dates), the State will not qualify for any of the additional funds authorized by the 1965 amendments.

Persons receiving public assistance because of old age, blindness, or disability can have their payments made to a third person if they have physical or mental impairments which make them unable to manage the payments themselves.

Federal public assistance funds can be used for aged persons who are patients in institutions for tuberculosis or mental diseases or who, because of a diagnosis of tuberculosis or mental disease, are patients in a medical institution. Federal aid can also be used for needy blind and disabled persons who are in general medical institutions because of a diagnosis of tuberculosis or mental disease. BUT Federal funds cannot be used for elderly patients in mental institutions unless the aid results in better care. The Federal aid cannot be used to reduce State or local expenditures.

From this date on, any decision about a State's public assistance plans made by the Secretary of Health, Education, and Welfare which would have the effect of denying Federal aid can be appealed in Federal courts.

MARCH 31, 1966

This is the deadline date for elderly people who are covered by social security (OASDI) to enroll for the voluntary medical insurance program if they want to be covered on July 1, 1966, the date the program goes into effect. All beneficiaries who reached their 65th birthday prior to January 1, 1966, are eligible. Persons who reach their 65th birthday after that date must enroll during the 3-month period before they become 65. The medical insurance payment of $3 a month must be taken out of the person's OASDI check, but his public assistance grant can be raised to compensate for the deduction.

JULY 1, 1966

On this date all persons over 65 are automatically covered under all of the hospital insurance provisions of the new legislation, except for the nursing home provision. Public assistance funds will be needed to pay the deductibles for those who cannot afford them.

Benefits under the voluntary medical insurance program will start for OASDI beneficiaries who signed up for it earlier and for elderly persons who receive public assistance payments in States that previously entered into an agreement for their coverage.

JANUARY 1, 1967

The nursing home provisions of the hospital insurance program become effective.

JULY 1, 1967

States that have set up the new medical assistance program can continue to get Federal support for it only if, by this date, they provide a minimum of five services: inpatient hospital services, outpatient hospital services, skilled nursing home services (for adults); physicians' services; and laboratory and X-ray services. Prior to this date, the new program can be limited to some institutional and some non-institutional care, the same as is now required in the medical assistance for the aged program.

JANUARY 1, 1968

This is the final date when States can enter into an agreement with the Secretary of Health, Education, and Welfare which would enable needy persons over 65 who are not covered by social security insurance (OASDI) to benefit from the medical insurance program.

JANUARY 1, 1970

Federal support of medical care programs for the needy will be withdrawn from States that have not established the new medical assistance program, covering, at a minimum, all recipients of public assistance and offering the five minimum services.

JULY 1, 1975

Prior to this date, it is expected that States will have provided, at their own expense, for medically indigent persons aged 21 to 65 who cannot qualify for care under the federally aided medical assistance program and will have included, in their federally aided program, all persons who meet the Federal eligibility requirements. In other words, all medically indigent persons in the State should be eligible for a broad program of medical care by this date.

Services provided through maternal and child health, crippled children, and child welfare programs should, by this date, be available to children in all parts of the State.

Training for Health Services for the Mentally Retarded

CLARA G. SCHIFFER*

THE GENERAL SHORTAGE of health manpower, the increased attention to the health needs of mentally retarded children, and the emphasis on a multidisciplinary approach in caring for these handicapped children have all contributed to an urgent need for training professional persons to work in the field of mental retardation. The 1965 amendments to the Social Security Act have recognized this need by making additional provision for grants for training purposes to be administered by the Children's Bureau.

The 1965 amendments authorize appropriations for grants "for training professional personnel for health and related care of crippled children, particularly mentally retarded children and children with multiple handicaps." The amounts authorized for this purpose are $5 million for fiscal year 1967, $10 million for fiscal year 1968, and $17.5 million for each fiscal year thereafter. The new grants are to be made to public or other nonprofit institutions of higher learning, and will be a major source of support of personnel who will staff the university-affiliated centers for diagnosis and treatment of the mentally retarded, which are now being constructed.

Project grants to assist in the construction of the university-affiliated centers were authorized by the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. In accordance with this legislation, the centers currently being planned will: (1) provide, as nearly as practicable, a full range of inpatient and outpatient services; (2) aid in demonstrating provision of specialized services for diagnosis, treatment, training, or care; and (3) aid in the clinical training of physicians and other specialized personnel needed for research, diagnosis, treatment, training, or care. The new grants authorized by the 1965 amendments open the way to carrying out the purposes of the centers by providing funds for staffing.

The 1965 legislation will enable the Children's Bureau to expand its present activities for training professional health personnel to work with mentally retarded children. Such programs have been the concern of the Bureau since fiscal year 1956, when appropriations were first earmarked for mental retardation programs. In 1963, the Maternal and Child Health and Mental Retardation Planning Amendments provided an important new stimulus to training activities. These amendments, with their provisions for larger appropriations and new programs, resulted in increased funds for training, although at the same time they increased the demand for trained personnel.

Training activities have encompassed many approaches: Grants for fellowships; support of and participation in institutes, conferences, and other short-term training sessions; consultation on course curriculums; arrangements for clinical experience in mental retardation clinics; and distribution of informational materials to professional workers. Also, because informational materials are an important training tool for professional workers, the Bureau has operated an exchange of educational materials as a

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service to mental retardation clinics. Since November 1961, through this exchange, approximately 275 different items have been distributed to each of the mental retardation clinics in the country, including clinics not supported by Children's Bureau funds. Special publications have been developed for professional personnel, and these have been much in demand. Proceedings of institutes have spread the knowledge provided by the institutes well beyond those actually in attendance.

The Children's Bureau has employed these methods in various ways recently in the major health disciplines involved:

PEDIATRICIANS

During fiscal year 1965 the Children's Bureau funded 27 pediatric fellowships in mental retardation. Training fellowships for pediatricians have had the requirement that the fellow be certified or eligible for certification by the specialty board. The fellowships are usually for 1 year. The majority have been located in clinical programs for the mentally retarded; most of these programs are in teaching hospitals associated or affiliated with medical schools. Training content has been confined largely to the clinical aspects of mental retardation, with some attempt to broaden the experience of the individual fellow by exposing him also to related training in neurology clinics, biochemical laboratories, etc. Relatively little effort has been made to present additional didactic material and course work, but recently there was established in two schools of public health a combined fellowship of 2 years in duration that will include training in both public health and mental retardation and will lead to an M.P.H. degree.

NURSES

The Children's Bureau has contributed to the preparation of nurses for service to retarded children in a number of ways. Since university schools of nursing prepare more than 80 percent of the faculty for all of the 1,128 schools of nursing, including hospital schools, "teaching the teachers" in these university schools has been a basic approach. The Bureau staff has brought information on mental retardation to university schools of nursing where sound programs in maternal and child health were already underway; the faculties have been asked to examine the total student program and to put appropriate emphasis on the care of the mentally retarded at all levels of education.

An example of this approach is the program of the Boston University School of Nursing, which integrates training in prevention of mental retardation and care of the mentally retarded into the curriculum in maternal and child care for all student nurses. In the academic year 1964-65 at this school there were in the graduate program 36 master's degree students who were gaining further knowledge and experience in working with the retarded, including 8 who were concentrating in this field. With the assistance of the Children's Bureau, the Schools of Nursing at the University of Washington, the University of California at San Francisco, the University of Utah, the University of Wisconsin, and the University of Iowa are also developing their undergraduate and graduate curriculums to give more emphasis to the care of the mentally retarded.

Nurses in diagnostic clinics who have developed a high degree of skill in the care of the mentally retarded can also be highly valuable teachers. With financial assistance from the Bureau, clinics can augment their staff to enable such nurses to devote most of their time to teaching.

In fiscal year 1966, several clinics are offering fellowships to nurses preparing for positions in the care of mentally retarded children. Also, workshops for nurses in service agencies and in teaching were offered during the summer of 1965 by the schools of nursing at the University of California in San Francisco, the University of Washington in Seattle, and the University of Iowa in Iowa City.

Short-term, intensive educational programs in mental retardation for practicing staff nurses complement more formal training in a university setting. In 1964, with direct financial assistance from the Children's Bureau, regional educational programs in mental retardation were held at Winston-Salem, N.C., and at Iowa City, Iowa, for nurses in positions of leadership in public health nursing, crippled children's services, and maternal and child health to help prepare them for a more active role in setting up educational programs for nurses at State and local levels. Reports of these two workshops have been distributed to nursing agencies and educational institutions throughout the United States. Also during 1964 the Children's Bureau offered consultation, staff participation, and assistance for at least 18 institutes and workshops on mental retardation for nurses at the State and local levels.

The Bureau encourages and assists the administrative, supervisory, and consultant nurses in State health departments in providing educational programs on mental retardation for nurses at the local level. In a few States, special consultant nurses in the care of mentally retarded children have been added to the maternal and child health staff.

DENTISTS

Training for dentists to work with retarded children is now being conducted at the Joseph Samuels Clinic, Rhode Island Hospital, in Providence. Approval has recently been given for a 1 year fellowship in pedodontics in the care of handicapped children at St. Christopher's Hospital, Philadelphia; this program is being developed in cooperation with the Temple University School of Dentistry. Another program to train dentists in caring for retarded children began at Baylor University School of Dentistry and Denton Training School in Texas on July 1, 1965. Additional programs for the training of dentists to work with retarded children can be anticipated.

There is also a great need to train dentists and auxiliary personnel, working in private practice or in hospitals, institutions, and clinical programs, in the special techniques required in the management of physically handicapped and mentally retarded children. An important step in the direction of stimulating interest in this problem was a conference held in March 1965 at the University of Tennessee to begin work on guidelines for dental care of mentally retarded children. When developed, these guidelines will be a valuable training tool for dental students and for dentists in private practice.

NUTRITIONISTS

With the assistance of Children's Bureau funds, nutritionists and dietitians have received training in how to deal with the overall nutritional problems of mental retardation, treatment for conditions such as phenylketonuria and galactosemia, and nutrition in group care of mentally retarded children. The major focus has been on providing inservice training to nutrition specialists already on the job, strengthening of clinical centers used for training, and improving the content of graduate training programs in regard to mental retardation. Since the enactment of the 1963 amendments there has been an acceleration of these activities.

The Children's Bureau in 1963 sponsored a national conference on Nutrition Services in Mental Retardation. The 100 conferees came from 38 States, the District of Columbia, and Puerto Rico and included public health nutritionists, pediatric dietitians, college instructors in nutrition and representatives from the Course Directors of Public Health Nutrition and Dietetic Internship Programs. This workshop, which focused on the training of leaders who were in key positions in relation to nutrition and mental retardation, stimulated additional training efforts in the States.

At least three States (Florida, Texas, and Massachusetts) have held statewide institutes on inborn errors of metabolism leading to mental retardation to train nutritionists and dietitians working in public health programs, hospitals, and other group care facilities, clinics, and universities. The prevention of mental retardation was the focus of an Institute on Nutrition in Maternity and Child Care held in 1964 in Oklahoma City, which attracted over 100 nutritionists, dietitians, and other professional workers associated with clinical services or teaching programs in Oklahoma and 10 surrounding States.

The Children's Bureau Nutrition Exchange has been regularly used to bring new reports and publications relating to mental retardation to the attention of nutritionists in State health agencies, directors of graduate training programs in public health nutrition, and other leaders in nutrition.

The Bureau has also worked to provide inservice training and field placement opportunities in mental retardation clinics for nutrition personnel, dietetic interns, and graduate students in nutrition. Because nutrition is a major factor in the care of mentally retarded children, the Bureau has recommended that a nutritionist be included on the multidisciplinary team in the clinical centers which offer training. Clinics have been able to establish positions for nutritionists with Children's Bureau funds. Currently, eight clinics, which have training functions, have positions for nutritionists.

The strengthening of graduate training curriculums for nutrition specialists in mental retardation has been another objective. The Children's Bureau provides special training grants in nutrition to 5 of the approximately 15 schools offering graduate training for public health nutritionists. The funds are used for fellowships or scholarships, for salaries of faculty or consultants, and for supporting services. The course directors of these graduate training programs have also received assistance in arranging for concurrent field experience in mental retardation services, securing qualified lecturers, and in obtaining reference materials. A Children's Bureau training grant has made possible the development of a new program of graduate training in maternal and child health for nutrition personnel at Western Reserve University in Cleveland. This 18-month course includes considerable training in the prevention and treatment of mental retardation and combines extensive supervised field and clinic experience in hospitals, clinics, and community agencies with didactic instruction.

CLINICAL PSYCHOLOGISTS

During fiscal year 1965, the Children's Bureau funded four fellowships for clinical psychologists in the field of mental retardation: one at the

Child Development Clinic in St. Louis; two at the Hamilton County Diagnostic Clinic in Cincinnati; and one at the Mental Retardation Unit of St. Christopher's Hospital, Philadelphia. These fellowship programs have been developed in settings where there is a good working relationship between the mental retardation clinical program, the department of pediatrics, and the department of psychology. They are providing the fellows with a well-rounded exposure to aspects of normal infant growth and development, as well as to problems of working with the physically handicapped and mentally retarded.

SOCIAL WORKERS

As the mental retardation clinic services have developed, they have been used increasingly for field instruction of social workers, an integral part of professional social work education. The very nature of these clinics, with their multidisciplinary approach, careful evaluation of children, and close relationships to the community, makes them particularly suited for the training of students of social work. The number of students placed in these clinics and the number of schools using these placements vary from year to year, but they are steadily increasing. In the 1964-65 academic year, it is estimated that 44 graduate social work students from 15 schools of social work derived all or part of their caseloads from these clinics.

Students from graduate schools of social work also received field instruction in other Children's Bureau-supported health programs which have mentally retarded children in their caseloads. In 1964-65, about 27 students from eight graduate schools of social work had field placements in six of these programs. The field instruction of social work students in clinics and other programs financed by Children's Bureau grants is provided by supervisors whose services are included in clinic projects or project grants to schools of social work.

Many of the mental retardation clinics provide short-term orientation ranging from a few days to several months for practicing social workers, particularly for those going into practice or education in mental retardation services. Opportunities for observation are provided by these clinics to social work students not assigned to them for field instruction. Short-term institutes and workshops for social workers and for multidisciplinary groups that include social workers have been developed by many clinics.

Two national workshops for social workers in mental retardation clinics have been financed by the Children's Bureau, and the papers presented have been published. The Children's Bureau publication, "Child Health Projects for Mentally Retarded Children--The Role of the Social Worker," resulted from such a workshop held by the Florida Department of Public Health in 1961. The District of Columbia Health Department publication, "Social Work in Child Health Projects for Mentally Retarded Children," which contains papers from that Department's 1963 workshop, was recently issued.

OCCUPATIONAL THERAPISTS

The approach to training of occupational therapists for expanded and improved service to the mentally retarded child has five major points of focus: (1) strengthening the preparation of the undergraduate, (2) conducting conferences, seminars, and short-term courses in new treatment theories and techniques for graduate therapists; (3) publishing the proceedings of conferences and seminars to increase the available literature on current concepts and practices; (4) promoting the utilization of occupational therapists in multidisciplinary evaluation and treatment programs for handicapped children; and (5) encouraging development of special projects by accredited schools of occupational therapy which will promote the above four objectives.

To further these aims the Children's Bureau worked with the University of Illinois in conducting a conference on "Occupational Therapy for the Multiply-Handicapped Child," held in Chicago, April 28-May 2, 1965. This conference featured 17 outstanding papers, to be published later this year, on various aspects of evaluation, treatment, and training, including 5 papers devoted entirely to programs for the mentally retarded. The conference was attended by 77 participants, half representing faculties of the 32 schools of occupational therapy which are approved by the American Medical Association and the remainder representing clinical programs throughout the country.

The Children's Bureau has also worked with the curriculum directors of selected schools of occupational therapy to discuss ways of strengthening undergraduate preparation and increasing opportunities for specialized graduate training for therapists to work in programs and services for children, including mentally retarded children.

In fiscal year 1966, four regional seminars will be held on perceptual-motor dysfunction. This is one of the major new fields in which a few occupational therapists have done outstanding work in the past 2 or 3 years. Employment of these people to teach the newer theories and techniques of this rapidly developing field would offer much needed short-term educational opportunities for occupational therapists working with the neurologically impaired child.

PHYSICAL THERAPISTS

All 42 schools of physical therapy approved by the American Medical Association and the

American Physical Therapy Association are presenting to their students some basic instruction on physical therapy for mentally retarded children, either in an institutional setting or in the special diagnostic and treatment clinics that are supported by Children's Bureau funds; for example, during fiscal year 1965, the Children's Hospital of Philadelphia, through its Children's Bureau Special Project, provided clinic experience for four physical therapy students from the University of Pennsylvania. This project also provided didactic courses for the junior and senior physical therapy students at the University.

With financial support from the Children's Bureau, symposia on various aspects of physical therapy for children with nervous system disorders, including mental retardation, have been conducted by the University of Pennsylvania with the cooperation of the American Physical Therapy Association and by Western Reserve University in Cleveland. Hundreds of physical therapists have attended these programs. A symposium concentrated on physical therapy of the mentally retarded child is being planned by the Division of Physical Therapy of Stanford University in Palo Alto, Calif.

SPEECH AND HEARING SPECIALISTS

Training project grants in audiology and speech pathology have been awarded Johns Hopkins University, Vanderbilt University, University of Iowa, University of Kansas, and Stanford University; each of these projects includes training related to mental retardation. In addition, a nonacademic clinical training program was instituted in 1964 through the Iowa Crippled Children's Services. Short-term conferences on speech and hearing services related to mental retardation have been held, and additional conferences are being planned.

CYTOGENETICISTS AND BIOCHEMISTS

As mental retardation clinical activities have expanded and new knowledge of medical genetics has become available, the Children's Bureau has begun to make grants for cytogenetic and biochemical laboratory services as extensions of mental retardation clinics. This has stimulated a need to train professional persons to work in these laboratories. The Children's Bureau funded during the fiscal year 1965 two fellowships in cytogenetics and two fellowships in biochemistry. The fellows in cytogenetics received both laboratory and clinical experience, one of them at the Diagnostic Clinic for Mentally Retarded Children in Birmingham, Ala., and the other at the Vanderbilt University School of Medicine in Nashville, Tenn. The fellowships in biochemistry were located at the School of Medicine at the State University of New York at Buffalo.

OTHERS

On a short-term basis, Bureau funds have been used to acquaint a wide variety of health, welfare, and educational personnel with the health problems of and services for the mentally retarded. In some of the special projects financed by the Bureau, staff have set up and conducted institutes for members of the clergy, police, etc., depending on local needs and concern.

SUMMARY

The preceding account of the Children's Bureau's training activities in health services for mentally retarded children points up the wide range of disciplines that are involved. Currently, Bureau funds are being used in the training of pediatricians, nurses, dentists, nutritionists, clinical psychologists, social workers, occupational therapists, physical therapists, speech and hearing therapists, cytogeneticists and biochemists, and others.

Training is provided through the funding of fellowships; support of institutes, seminars, and other short-term educational programs; strengthening of course curriculums; arrangements for clinical experience; and distribution of informational materials.

These activities represent progress in filling the great need for professional persons with a knowledge of mental retardation. Although trained personnel are still in short supply, as additional funds become available it can be expected that training activities will increase. The 1965 amendments strengthen the resources for training professional health personnel through their authorization of grants to institutions of higher learning, including the university-affiliated centers for diagnosis and treatment, 22 of which are now in the planning stage.

The outlook for training increasing numbers of health personnel to provide services to mentally retarded children is definitely brightening.

Low-Income Outlook on Life

LOLA M. IRELAN and ARTHUR BESNER*

This paper and the one following on "Economic Deprivation and Family Patterns" are from a series of research essays on low-income life styles that the Division of Research is preparing as part of its continuing effort to promote utilization of existing research.

Each paper will present in condensed form the available research findings concerning effects of economic deprivation on a specific area of American life. "Low-Income Outlook on Life" describes the matrix of attitudes and values in which lower class life is embedded. "Economic Deprivation and Family Patterns" outlines the characteristics of family life at the low-income level. Two subsequent papers, which will also appear in Welfare in Review, will summarize the effects of low-income upon health attitudes and behavior and the typical consumer behavior of the poor.

The series identifies and inventories the uniformities of life conditions which, in the light of current knowledge, seem to be typical of the very poor. In order to present the common generalizations gleaned from several hundred research sources, discussion of the variations in behavior as clinically observed has been purposely avoided.

CURRENTLY, in our national concern for the alleviation of poverty and economic dependency, the need to know and understand what life looks like from the bottom of society is a crucial one. We can induce meaningful change only if we understand the situation where we intend it to occur. It is unlikely, for example, that we can change or reduce rates of dependency and poverty without knowing what the conditions of dependence and deprivation mean to people caught up in them. Nor can we bring any class of people into a different relationship to society without knowing the quality of the existing situation.

As yet, knowledge of this sort is fugitive and tenuous. Much needed research has yet to be designed. There are gaps and flaws in the exploratory research which has been done. The findings on hand are suggestive rather than definitive. There is enough known, however, to warrant inventory and judicious application. It behooves us to systematize and use such knowledge as we do have. In the long run, such a step will serve to refine and increase it.

This paper summarizes available findings, largely from studies in the United States, bearing on the approach to life of the poor, the people at the bottom of society's economic ladder. It will discuss the connection between the condition of poverty, the views of man and society which arise there, and the apparent effect of those views on the lower class version of American goals and values.

LIFE CONDITIONS OF THE POOR

In our society, a continuously low income is directly associated with certain life situations. Poorer, more crowded living quarters, reduced access to educa-

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For references cited, see end of article.

tion and recreation, occupational restriction to simpler, manual types of work--these and similar characteristics of the very poor are sufficiently obvious to need no underlining. The result of these circumstances is a set of life conditions which is not so obvious. They consist of four general limitations: (1) comparative simplification of the experience world, (2) powerlessness, (3) deprivation, and (4) insecurity. These limitations are, of course, relative. Indeed, they can be discerned only because of the different extent of their existence at the several levels of society.

1. Limited alternatives. The poor, of all the strata in society, have the slightest opportunity to experience varieties of social and cultural settings. Their own setting is one of the least intricacy and flexibility. Throughout life, they experience a very narrow range of situations and demands. Their repertoire of social roles is limited. They seldom participate in any activity which takes them out of the daily routine. They rarely play roles of leadership, or fill any position calling for specialized functioning. On their jobs, they confront less complex situations and have fewer, less diverse standards to meet. Socially, they seldom go beyond the borders of kinship and neighborhood groups--people very like themselves.[1]

2. Helplessness. The position of the poor vis-a-vis society and its institutions is one of impotence. They have practically no bargaining power in the working world. Unskilled and uneducated, they are the most easily replaced workers. The skills they do have are minimal, of little importance in productive processes. On the job itself, the very poor man can exercise little autonomy and has small opportunity to influence conditions of work. He is close to helpless even to acquire information and training which would change this situation. He has neither the knowledge nor the means to get it.

3. Deprivation. It is reasonable to suspect that this general condition, almost universally associated with poverty, is felt with particular intensity in American society. Deprivation is, after all, relative. When it is defined as lack of resources relative to felt wants and needs, it is evident that America has one of the greatest gaps between generally accepted goals and the extent to which the lower class can realistically expect to attain them. As a nation, we stress, perhaps inordinately, the value and virtue of high attainment. We expect and applaud efforts at self-improvement and upward social mobility. Commercial advertising attempts to stimulate and increase desire for status achievement. The richness of life in the rest of society is well displayed--on television, in newspapers, on billboards, in store windows, on the very streets themselves. All this, plus awareness that some people have actually succeeded in the strenuous upward move, makes the condition of the unachieving poor one of unremitting deprivation. Their relative deprivation is, perhaps, the condition which more than anything else affects the life-view of the poor. Constant awareness of their own abject status and the "failure" which it rightly or wrongly implies understandably leads to embarrassed withdrawal and isolation.

4. Insecurity. People of low income are more at the mercy of life's unpredictability than are the more affluent. Sickness, injury, loss of work, legal problems--a range of hazardous possibilities--may overwhelm anyone. But to the poor man they are especially fearful. His resources are more sparse. His savings, if any, are quickly expended in any sizable emergency. Certain conditions of his life make emergencies more likely. His work skills are more expendable, sometimes more dependent on seasonal demands. He is more likely to lose his job on short notice. An emergency expenditure of funds may mean the postponing of rent payments and the fear of eviction. He is unable to secure for himself and his family the regular, preventive health measures which would fend off medical emergencies. He often finds that he cannot successfully navigate the channels involved in using public sources of emergency help, such as clinics and legal aid agencies.[2]

Constant, fruitless struggle with these conditions is likely to produce estrangement--from society, from other individuals, even from oneself. The wholeness of life which most of us experience--the conjunction of values, knowledge, and behavior which gives life unity and meaning--is less often felt by the poor. They see life rather as unpatterned and unpredictable, a congeries of events in which they have no part and over which they have no control.

Conceptualized as "alienation," this view of life is repeatedly found associated with lower social and economic status.[3] It is multifaceted--despair can be generated and felt in many ways. Generally, however, it seems to have four different forms of expression. The alienation of the poor is graphically seen in their feelings of: (1) powerlessness, (2) meaninglessness, (3) anomia, and (4) isolation.

1. Powerlessness. The objective condition of helplessness in relation to the larger social order leads naturally to the conviction that one cannot control it. The poor are widely convinced that individuals cannot influence the workings of society. Furthermore, they doubt the possibility of being able to influence their own lives. Correspondingly, they are likely to voice such pessimistic views as, "A body just can't take nothing for granted; you just have to live from day to day and hope the sun will shine tomorrow."[4]

2. Meaninglessness. Powerlessness, the feeling of being used for purposes not one's own, usually is accompanied by conviction of meaninglessness. The alien conditions in which an individual may be caught up tend to be unintelligible. He does not grasp the structure of the world in which he lives, cannot understand his place in it, and never knows what to expect from it. Oriented, by need, to the present, he is relatively insensitive to sequences in time. He often does not understand the continuity of past experiences and current ones. And, not only does the poor man feel unable to control future events, he cannot even predict them.

3. Anomia. The term "anomie" was originally coined to describe situations in which social standards have broken down, or have no influence upon behavior.[5] It has subsequently been pointed out that this normless condition is a probable result of the failure of prescribed behavior to lead one to expected goals.[6] The life view of individuals caught in such a discrepant situation is likely to be cynical, perhaps fatalistic. For example, the poor man who is taught in many ways that economic success is the most desirable thing in life--and then is barred from legitimate means of achieving it--may come to expect that illegal behavior is necessary to reach approved goals. The situation, moreover, induces people to believe in luck. The poor are in no position to comprehend the whole of society's structure and operation, or to understand its dysfunctions. Since they also have little control over it, its impact on them is frequently fortuitous. Understandably, they are quick to credit their difficulties to fortune and chance.[7]

4. Isolation. More than any other segment of society, the very lowest economic stratum is socially isolated. The poor man not only fails to comprehend society or his community, he is out of touch with it. He reads fewer newspapers, hears fewer news programs, joins fewer organizations, and knows less of the current life of either the community or the larger world than more prosperous, better educated people do. Nor do the poor associate among themselves more than minimally.[8] Experiencing separation from society and each other, it is natural for them to feel alone and detached. And feeling no identity, even with each other, they view the world as indifferent and distant--"No one is going to care much what happens to you when you get right down to it."[9]

GOALS AND VALUES

What are the aims of life in such circumstances? In a situation of relative helplessness, knowing themselves worse

off than the rest of society, living on the edge of chronic emergencies, and seeing their own circumstances as formless and unpredictable, how do the poor shape their lives? What values do they hold? What goals do they seek? Essentially, they seek and value the same things as other Americans. Naturally enough, since they are American poor, they absorb characteristic American values and preferences. And, just as naturally, the realities of low economic status are visible in the lower class version of American dreams and designs. The result is a constricted but recognizable variant of society-wide goals and standards.

Increased sophistication of research on lower income and deprived groups is correcting a long-held impression that the poor place no value on occupational and educational achievement. While the poor do have a more modest absolute standard of achievement than do those who are better off, they want relatively more improvement in their condition. They value the same material comforts and luxuries. Psychologically, they seek the securities that appeal to other Americans. They hold, with little qualification, to the same proprieties of social conduct.

Interest in improving one's status, however, seems to have different sources at different social levels. To the middle-class youth, the idea of having a better job than his father is appealing, sometimes absorbing. Such achievement is attractive in itself. A lower class youngster has more urgent, material reasons for wanting an improved future. His present is painfully unsatisfactory. His urge toward better, stabler occupations is not so much drive for achievement as flight from discomfort and deprivation. It is probably stronger for that difference.[10]

Reality--expenses of education and training, lack of resources--usually keeps less well-off high school students from aspiring to the highest level professions. But, more than their middle-class fellows, lower class high school students want better jobs than their fathers'. They are more likely to value increased income. In significantly greater numbers, they are unwilling to enter the same occupations as their fathers.[11]

Although they may not expect to achieve it, most low-income people value advanced education. It has been found that up to 65 percent of parents will say they want a college education for their children.[12]

Materially, the lower classes are not satisfied with poor housing or living conditions. High on their list of desirable improvements are better housing and neighborhoods. Inside their homes, they value the same things as the general run of Americans--comfortable and durable furniture, a television set, an array of electrical appliances, and, to give life grace as well as comfort, a few ornaments and art objects. Tastes in style are definitely American--modern furniture, colored telephones, pole lamps, systematic color schemes.[13] It sometimes happens, as in more affluent circumstances, that materialistic values win out over real human needs. Parents stint on children's clothing to save money for a car. Older children are pressed too early into adult responsibilities because both parents are working away from the home.[14] A woman postpones an operation for herself because the family must have a car or a radio.[15]

In common with other Americans, the lower class enjoys excitement and values the opportunity to escape routines and pressures of day-to-day existence. Spectator sports, television, visiting--all are valued leisure-time pursuits.[16]

Probably the most basic value held by the poor is that of security. Even more than "getting ahead," they value "getting by," avoiding the worsening of an already unstable situation.[17] They are unwilling to take risks, and seek security rather than advancement--also a frequent pattern in economically better off segments of the population.[18]

The moral code of the very lowest class is a moot subject. It has been said that they have an entirely separate set of moral and ethical values. They have also been described as subscribing so fully to the general American code that they are frustrated by it.[19] The most

realistic conception seems to be that which credits them with an adapted version of society's rules of behavior. They value stable marriages, perhaps even more highly than do middle-class Americans. They do not, however, reject out of hand other forms of sex partnership. A sliding scale seems to exist, whereon a good common-law marriage is valued less than legal union, but more than a transient arrangement. Illegitimacy is not devalued to the extent that it is elsewhere. Legitimate families are the ideal, but there is also some merit ascribed to the parent who acknowledges and supports children born out of wedlock.[20]

LIFE THEMES

The anomaly of life at the poverty line is evident. When people live in conditions of such obvious helplessness, when they are themselves so aware of their condition as to feel alienated and apart from society, how can they retain, much less implement, the values of that society?

The apparent answer is reinterpretation. Paths to achievement, to security, to any goal--the very quality of the goal itself--are refracted by the lower class view of life. They are interpreted in the light of what the poor man considers to be facts about life. The helplessness which he feels, the insecurity he experiences, the meaninglessness of life--all have their effect upon the way he lives and behaves.

There are four distinctive themes peculiar to lower class behavior, all apparently the result of a deprived, alienated condition: fatalism, orientation to the present, authoritarianism, and concreteness.

The genuine powerlessness experienced by the lower class is the source of persistent fatalistic beliefs. The natural counterpart of feeling helpless is belief in uncontrollable external forces. The attitude is reminiscent of belief in fate. People cannot avoid what is going to happen to them. Resignation is the most realistic approach to life.[21] Even when optimism is expressed, it is likely to be in terms of the working of chance--"A poor person should never give up hope; there's always a chance that a lucky break will put him on top."[22] This attitude acts as a definite brake on occupational and educational aspirations, and retards health care. In various other ways fatalism minimizes efforts to cope with deprivation and its consequences.

Hand in hand with fatalism goes a persistent tendency to think in terms of the present rather than the future. It is, after all, fruitless to pay attention to the distant future or try to plan life when fortune and chance are considered its basic elements. Also, when so much of one's resources must be expended simply to survive the present, little is left over for the future.[23] Results of this ad hoc orientation are pervasive. It handicaps people for the planning required in systematic economic improvement. It works against the frugality and rainy-day planning which could offset economic dependency. In the home, it results in child-training in terms of immediate reward and punishment. Children quickly evince their own present-time thinking. This low concern for future goals has been shown to be related to low academic achievement[24]--and the cycle continues.

The authoritarian theme is a strong underlying factor in interpersonal relationships of the poor. Generally defined, it is the embodiment of belief, more prevalent in the lower classes than elsewhere, in the validity of strength as the source of authority, and in the rightness of existing systems. It seems to arise from simplification of life experiences, in which one learns to prefer simple solutions to problems, and from constant subordination of the poor. Authoritarianism is incarnate in the habit of classifying people as either "weak" or "strong," in belief that deviance or disobedience should be severely punished, and in reliance on authority, rather than reason, as the proper source of decisions. It has traceable effects on family relations, child-rearing patterns, and relation to community institutions--schools, clinics, the police, welfare agencies, even to churches.[25]

Concreteness, stress on material rather than intellectual things, is a believable but little-discussed theme of lower class life. It is natural to people preoccupied by material problems. It shows itself in verbal patterns, in distrust of intellectualism, and in occupational values.

The concrete verbal style of the poor has been well-documented.[26] It is characterized by less abstraction, fewer concepts, more frequent reference to concrete objects and situations, and a less discursive manner. It includes fewer generalizations, relies less on intellectual processes than on observation, and is more tied to the world of immediate happenings and sensations.

Consistent with its patterns of speech, the lower class inclines to withhold its admiration from "eggheads," reserving it instead for the practical, down-to-earth man of action. What counts is not abstract, intellectual pursuits, but the hard, tangible products of action. Results are important.[27]

This pragmatic orientation has a vital effect upon the occupational values of the lower classes. They have been found, at as early an age as 10 years, to value occupations for more tangible rewards rather than for intellectual or emotional ones. That is, a boy will aspire to a certain profession because of what it offers in terms of money and prestige rather than the nature of the work itself.[28]

SUMMARY AND IMPLICATIONS

Our lower income population is insecure and comparatively powerless in relation to the rest of American society. Realizing their submerged position, they have come to feel apart from society rather than part of it. From their own helplessness, they have generalized to the belief that most of life is uncontrollable. They are convinced of their own impotence so that, while they accept typical American values they are frequently lethargic in trying to attain them.

It would be incautious, in view of the sparseness of our knowledge, to say just what program implications such knowledge has, or what techniques of improvement are most likely to succeed. But it would be irresponsible to close this discussion without underlining the precautions it suggests:

1. The entire life situation of the poor must be considered if any part of it is to be changed. Their attitudes arise in no vacuum but are logical results of real circumstances.

2. Lower class citizens must be brought off the periphery into the structure of the community. Nothing which the community does for them can be durably effective until they are a functioning part of the community.

3. Energetic patience must prevail. The alienated adult cannot be completely reeducated. His children can be somewhat swayed. But it is with his grandchildren that one can really have hope.

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Economic level and degree of agreement with the statement, "A poor person should never give up hope; there's always a chance that a lucky break will put him on top."

Economic level*	Percent indicating--	
	Strong agreement	Little or no agreement
Poor (N=169)	31	69
Not poor (N=166)	18	82
Percent difference	13	13

*According to the measure developed by James Morgan, et al., in Income and Welfare in the United States. McGraw-Hill, New York, 1962, pp. 188-196.

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An example of this trait is the recent finding by Leonard Goodman (Welfare Administration Cooperative Research Project No. 125) on poor people's agreement with a present-oriented statement:

Economic level and degree of agreement with the statement, "Nowadays a person has to live pretty much for today and let tomorrow take care of itself."

Economic level	Percent indicating--	
	Agreement	Disagreement
Poor (N=169)	48	52
Not poor (N=166)	34	66
Percent difference*	14	14

*Significant at less than the .05 confidence level.

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Economic Deprivation and Family Patterns

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THE ELEMENTAL PLACE of the family in every person's life and the primacy of its influence make it a factor to be reckoned with in any effort at long-term change, either in society or in the individual. If, for example, we are to intervene successfully in the lives of the several million children in families receiving public assistance, we must at least know the outlines of their home environments. Otherwise, we are likely to miss the most vital points of leverage for our efforts.

Since family patterns are responsive to basic life conditions, the relative prevalence of different types of families varies between societies and between segments of a single society. Research to date seems to show that in the United States economic deprivation is associated with relatively more frequent occurrence of some family types and with characteristic differences in the internal functioning of the classic two-parent nuclear family.

Some of the most significant of these features are revealed in the typical lower class courtship, adjustment to marriage, division of marital responsibilities, marital values, peculiarities of the single-parent family, and child-rearing patterns.

COURTSHIP

In the very selection of a spouse, lower class men and women manifest several of the attitudes highlighted in the preceding paper. For instance, there is some evidence that they do not regard themselves as active choosers of mates.[1] This fatalism or sense of powerlessness may be responsible, in part, for the relative lack of initiative displayed during courtship.

In comparison with other social classes, the American poor are influenced more by residential proximity in selection of marriage partners.[2] This appears consistent with the lower class reluctance to contract primary social relationships outside the immediate environment.[3] Another contrast is the relative absence of strong feelings about the decision to marry. This is not surprising in view of the lower class inclination to fatalism and the consequent belief that one cannot control even the selection of a marriage partner.

Courtship is frequently of short duration. In one study of the marriage patterns of the poor, the typical responses to a question about the decision to marry were--"We just did it"; "It was just time"; "Somehow it was settled."[4] What is also to be expected is a lack of elaboration in planning marriage (possibly related to the shortened time perspective of the class), and corroborating findings are beginning to emerge.

ASPECTS OF EARLY ADJUSTMENT TO MARRIAGE

Discernible from the very beginning of the typical lower class marriage is a pattern that seems to permeate the entire family organization. This is the relative emotional isolation of spouses from each other. In contrast to the typical newly married couple in the middle class, lower class partners cling to old friendship and kinship ties rather than reorganize ties to make each partner com-

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See headnote for previous article. For references cited, see end of article.

fortable in moving within one network. For example, the middle-class couple typically will drop from their circle of close friends those persons who are unacceptable to either spouse. This is not generally true for the lower class couple.[5] Individual choice is not the only or even the most important motivation operating to produce this pattern. Poverty lends itself to it, for each partner must cling to time-tested ties as insurance against the future.

Needs which are not satisfied through the conjugal family may be supplied through friends and relatives. In a comprehensive West Coast Study of social class, it was reported that lower class persons interact more with their kin, absolutely as well as relatively to their interaction with others.[6] The individual quality of these relationships may make them valued, particularly when they provide means of avoiding potentially painful encounters with institutional sources of support. Analysis of data collected by the Bureau of Social Science Research, in connection with a project supported by the Welfare Administration,[7] showed that the poor, in comparison with the non-poor, receive substantially more help from relatives:

Extent of aid received from kin, by economic level.

Economic level	Percent receiving different levels of aid	
	Moderate or less	More than moderate
Poor (N=169)	76	24
Not poor (N=166)	87	13
Percent difference*	11	11

*Significant at less than the .02 confidence level.

DIVISION OF MARITAL RESPONSIBILITIES

That the lower class family is a relatively loose structure rather than a tightly unified social entity becomes more apparent as one analyzes the roles of the marriage partners. The division of their responsibilities is formal. Each partner is something of a specialist who relates to the other as a specialist.[8] For example, in many of the homes of the poor there is a sharp demarcation of roles according to whether the jobs are inside or outside the house.[9] This is in contrast to the more flexible pattern in the middle-class home, where the needs of the family are usually satisfied through joint planning and sharing of domestic and social functions. To illustrate, child-rearing is usually within the domain of the wife in the lower class while both parents in the middle class usually expect to be involved in the socialization of children. There is division of labor in the middle-class home, but it is relatively fluid; an interest in doing things together allows interchangeability in roles.[10] The firmer lines of authority drawn in the lower class home serve to reinforce the pattern of psychological isolation and to maintain the emotional distance between spouses by limiting permissible channels for communication.[11]

More research is needed on the distribution of responsibility in families, but available information suggests an inverse relationship between social status and the degree of responsibility assumed by the wife.[12] That is, the lower class wife has relatively more duties than either the middle or upper status wife or the lower class husband. There are several studies which show that the lower class wife has more influence in family decision-making than housewives on other socioeconomic levels.

This is especially noticeable in the area of family financial management. As socioeconomic status decreases, there is more tendency to feel that "earning the money is the man's responsibility; spending it wisely is the woman's duty."[13] The husband's role in finances thus ends after delivery of his paycheck. In contrast, the middle-class couple most commonly share decisions over major purchases and reach some measure of agreement over the portion of the budget allotted to the wife for daily purchases. The middle-class hus-

band has a definite role. In fact, it has been said that he serves as "architect of the family's fiscal policy," determining the proportion which should be saved, designing the insurance program, and planning how to invest any extra money.[14] Economic conditions may have much to do with these contrasting patterns. When a large proportion of income is consigned to routine necessities, there is less need for joint functioning.

Even in those areas in which sharing is culturally prescribed, lower class husbands have a low rate of performance. For example, compared with upper and middle-class husbands, they are less likely to share in the supervision of the children's school work, to decide on family insurance, or plan vacations.[15]

The great differential in the distribution of responsibilities between the husband and wife suggests that the husband plays a minimal role in the low-income home. He seems to conceive of his responsibility as being the simple provision of money to meet material needs.[16] Nevertheless, he does seem to expect a periodic reassurance of at least a titular authority,[17] while at the same time demanding freedom to come and go at will. As a result, the lower class wife performs the majority of functions in the home mostly by her husband's default rather than through a usurpation of power.

MARITAL VALUES

The emotional distance between lower class husbands and wives supports, and is in turn reinforced by, a disparity in marital values. Their initial isolation from each other prevents the kind of exchange which could reconcile their opposing needs. Lower class men and women are likely to see themselves as opposed to each other and belonging to quite different worlds.[18] There is little joint social participation either within or outside the home; family members usually go their separate ways in search of diversion.[19] There are comparatively few instances of friends in common, and visiting as a family group seldom extends beyond a narrowly circumscribed kinship circle.[20]

Anthropologists have ascribed a "cult of masculine superiority" to the lower class, and this would seem to be another force producing and maintaining the isolation between husband and wife. Researchers have found from analyses of interviews with low-income men and women that, in relation to one another, the men feel dominant and the women downtrodden.[21] This seems to be the case even in face of the fact that many low-income women, particularly low-income Negro women, can more easily obtain and hold jobs than the men.[22]

Interestingly, it has been found that lower class men and women also tend to view each other much as the class, as a whole, perceives the external world. Thus men are described by the women as unpredictable, difficult to understand, inconsiderate, and overwhelming. Similarly, lower class husbands tend to think of women as temperamental, emotional, demanding, and irrational.[23]

Isolation, as well as a great deal of friction, may arise from the general expectations lower class husbands and wives have of each other. It was implied in the discussion on the division of responsibilities that the husband regards the home simply as a retreat for the satisfaction of physical needs. Accordingly, the husband places primary value on the non-emotional aspects of the wife's role. A "good wife," for him, is one who prepares the meals for the family, keeps his clothing in order, raises the children, and frees him from everyday worries. In short, the husband conceptualizes the wife's role as housekeeper-mother. This is antithetical to the wife's wish for emphasis on the interpersonal aspects of marriage, the friend-lover role. Her wish for open expression of affection is not met by the husband who does not see this as important.[24] It is not that she resists the performance of household and motherly duties, rather she resents the husband's limitation of the marital relationship to them. It has been suggested that much of the tension observed in the families

of the poor arises from this basic conflict in role expectation.

Hence, the lower class wife must endure emotional deprivation as well as the ever-present fear of physical-economic deprivation. She is handicapped, however, by her subservient position vis-a-vis her husband and by her view of men, from managing the marital relationship to serve her needs better. What might also be thought of as a handicap is the special significance of marriage to the lower class woman. Women in the lower socioeconomic strata are likely to find it difficult to think of themselves other than in a familial role. They tend to feel somewhat lost after outgrowing the daughter role and look to the wife-mother role to regain a clear-cut familial status. Some family sociologists have suggested this as a reason for the fact that women in the lower socioeconomic classes marry at a younger age than women in higher social classes.[25] Furthermore, from the lower class woman's viewpoint, a husband offers the most tangible opportunity for love and security and represents a defense against the workings of the unpredictable world. The wife is thus wary about asserting herself against the husband lest he should leave her, though the gap between the ideal and the real husband is great.

The special significance of motherhood to the lower class woman may arise from economic deprivation as well as the emotional deprivation in the husband-wife relationship. Being denied most of the tangible and intangible satisfactions of marriage, the lower class woman defines herself mainly as a mother and seeks gratification in life through this function. The limited outside interests of the lower class woman also increase the significance of motherhood. Children may represent compensation for the husband's lack of attention and for the dullness of life. The mother-child relationship is considered by many students to be the strongest and most enduring family tie in the lower class. A recent study of lower class women in Philadelphia illustrates the greater significance attached to the role of mother as opposed to that of a wife. Specifically, the mothers were asked: "If you could only be a wife or mother (but not both) which would you choose?" The majority of these women, in both the single and paired parent groups, chose the mother's role.[26]

The passive role of the father in the home seems to strengthen the dependence of children on the mother. Lower class children, studies report, are reluctant to confide in the father. Those who try may experience rebuffs from the fathers who maintain independence from child-rearing or may be discouraged by mothers.[27]

THE SINGLE-PARENT FAMILY IN THE LOWER CLASS

The characteristics of lower class family life seem to be crystallized most intensely in the single-parent family. The female-based household is a widely prevalent and persisting form among the poor. It has been estimated that between 25 and 40 percent of the child-rearing units in urban "slum" areas are of this type.[28] Usually such a household will consist of one or more women of child-bearing age, often related by blood or through marriage and spanning two or more generations--for example, the "single parent" and her mother and/or aunt. Associated with this household type is a marriage pattern in which the woman has a succession of temporary partners during her procreative years.[28]

Some research suggests that this type of family is not entirely disadvantageous. We have noted the minimal significance of the husband and father in some lower class families and his insistence on being recognized as the family head without making substantial contributions. Frequently it is the husband who is the economic burden--lower class women often realize more success in obtaining and holding a job than the men. It may be a gamble to marry and risk losing control over a low but stable income. In short, middle-class ideals of marriage for economic support, love and companionship simply are not realistic for many lower class women. Need for love and companionship and the

desire for children lead some of these women to enter into brief nonlegal unions.

The greater bulk of research, however, points out the dysfunctions of single-parent families. For children, the effects of the absence or only sporadic presence of a father are detrimental to emotional and social development. There are detailed studies which report a wide range of negative conditions associated with absence of the father. For example, such children, when compared under clinical observation with children who have fathers present in the home, are discovered to suffer from difficulty in resolving the oedipal conflict, overattachment and dependence on the mother, and lack of a solid basis for the development of both masculine and feminine roles.[29] More than other children, they experience unsatisfactory peer group relations and feel inferior and insecure.[30] Some studies have shown that these children focus more on the immediate than the future, a fact which has consequences for educational achievement and social mobility. Many of these children react as if they feel personally responsible for the father's absence. They often consider themselves unlovable and develop feelings of self-derogation. There is evidence that such children see love relationships between the sexes as being capricious.[31]

As noted earlier, lower class women develop great emotional attachment to children as compensation for the emotional distance and lack of communication with their husbands. With absence of the adult male, this pattern sometimes intensifies.

A peer relationship often develops between the mother and her children of either sex. A son is sometimes expected to contribute economically and become the man of the house before he is really able.[32] This may also propel him to marriage before he has the training and background necessary to cope with its economic demands. Sometimes, older daughters are seen as rivals, competing with the mother for the attention of male acquaintances.[33] The prematurely adult role of a daughter is augmented when she has to become a houskeeper and part-time mother.

For the mother, however less painful it may be not to have to tolerate an unsatisfying marital relationship, the absence of a permanent adult male presents practical problems. She must usually take a job to support the family. Other functions discharged by the husband, however few these are in the lower class two-parent setting, also must be assumed. In short, she must engage in activities and to some degree manifest attributes generally associated with the adult male. There is also the problem of housing. In some jurisdictions, the policy of public housing discriminates against the female-based household.[34] This offers a strange dilemma since public housing is primarily for the poor and the female-headed household is a frequent family type among the poor.[35]

CHILD-REARING

Research on American child-rearing patterns has suffered from hazily defined concepts and from failure to explore the meaning as well as the pattern of behavior. Recent studies have moved toward correcting these lacks. However, it is still necessary to be cautious in using reported findings.

With this caveat in mind, it is nevertheless possible to list some of the effects of lower class status on the way children are reared.

Much of the earlier work concerned itself with techniques involved in child-rearing. Attention was paid to comparing the practices of different social classes on factors like weaning and feeding, cleanliness training, thumbsucking, techniques of discipline, aggression control,[36] etc. But even in the employment of this simple conceptual framework there were many inconsistencies in the findings. In some of the studies, middle-class parents were generally reported to be more exacting in their expectations. Training was reported to begin earlier than in the lower class home, with more emphasis on early training for responsibility and close

supervision of children's activities. On the other hand, there were studies in which these trends went in the opposite direction.[37]

Recent studies have begun to probe the background of child-rearing techniques--the purposes for which parents do what they do in relation to their children.[38] Lower class parents appear more concerned with the development of "respectable" behavior in children--obedience, neatness, and cleanliness. Emphasis on discipline is particularly strict. Incidental findings of a recent study in Baltimore[7] reveal a significant 9 percent difference between poor and non-poor parents in emphasis on obedience:

Economic level and agreement with the statement, "Obedience is the most important thing for parents to teach their children."

Economic level	Percent indicating agreement
Poor (N=169)	26
Not poor (N=166)	17
Percent difference*	9

*Significant at the .05 confidence level.

Middle-class parents can take respectability for granted. Child-rearing can center on developing self-reliance and independence in children and on encouraging their full realization of potentialities. These values, it should be noted, are voiced also by low-income parents. At this level, however, respectability is a more urgent need and is, therefore, more strongly emphasized in the training of children.

Most current research and a large part of the older data can be summarized in the statement that lower classes tend to be more "traditional" in raising their children, while the more affluent are able to emphasize " developmental" principles.[39] The traditional attitude values the physical duties performed by parents. The attention of parents is to maintenance functions--providing food for the children, making sure that they are clean and get sufficient rest, etc. The goal is to steer children to conformity with patterns of being neat and clean, obedient and respectful of parents, polite and socially acceptable. Here roles and parent-child interaction patterns are rigid and oriented toward maintaining order and discipline.[40]

Middle-class parents are more concerned with psychological growth and development than with specific behavioral conformities. Permissive guidance, with parents training children for self-reliance, encouraging independence, and providing intellectual stimulation, is the keynote. Roles and patterns of interaction between parent and child are dynamic and flexible. The child has wide latitude in which to develop and express himself.

Several explanations have been advanced and explored for this class differential. Traditional child-rearing can be considered natural to a milieu of economic deprivation where the focus must be on the physical, rather than the introspective, aspect of life. Income stability, on the other hand, allows parents to concentrate on the inner dynamics of children--their motivations and feelings.[41] Such consideration of inner development would be especially difficult for the poor because of their usually low educational backgrounds and relative inability to deal with the abstract.

Occupational experiences probably have great effects on the behavior of parents and on their expectations of children. The occupations of the poor involve manipulation of physical objects at a comparatively unskilled level under routine and direct supervision. In contrast, members of the middle and higher strata manipulate ideas and symbols in their occupations. When they do manipulate physical objects, it is at a more skilled level. They also enjoy more independence and self-direction in their work. The rigid and ordered behavior of lower class homes are understandable as carry-overs from their occupational setting. The middle-class parents' attention to the internal dynamics of the child and their

more flexible attitudes toward his behavior are natural extensions of their occupational climate. Traits esteemed in children follow the same pattern. Traits encouraged by lower class parents--obedience, politeness, etc.--are those which are functional to low occupational jobs. On the other hand, traits that middle-class parents value in children--responsibility, initiative, independence, etc.--are themselves traits functional to success in the middle-class occupational life.[42]

SUMMARY AND IMPLICATIONS

The low-income American family is a qualitative variant of the national family type. Differences are of degree rather than of type. The nuclear lower class family is generally less close-knit. Husbands and wives have fewer overlapping responsibilities, with the wife having more responsibility alloted to her than is true in the middle class. Greater possibility for husband-wife conflict exists due to lack of agreement on what is expected from marriage. The single-parent family, headed by a woman, is more frequent. Child-rearing patterns concentrate more on discipline and conformity training than on psychological development of the child.

Poverty and dependency, which this generation of Americans has committed itself to destroying, must be grappled with in its nuclear setting--the family life of the poor. More research will increase and make more useful the knowledge which has been summarized here. Meanwhile, on the basis of the information that we have, we can be very hopeful. We know that low-income parents do value better material lives for their children. We know that they are concerned for their children's psychological health and development but lack both knowledge and opportunity to implement their concern.

Any attempt to reach these parents with help, through information, training, material aid, or indigenous action programs, must be planned to allow for:

1. The possible lack of understanding or consensus between husbands and wives. From what we now know, women appear to have a greater investment in family life than do their husbands. They are probably better targets for educational programs and for any attempt to bring the lower class in from society's perimeter. Their own present needs would be served by efforts to help them help their children. Lower class husbands, on the other hand, may feel threatened by attempts to upgrade the family or its children. Intervention programs must be planned so as to serve the needs of the entire family and to allow for the emotional and communicative isolation within it. This would be particularly true in the area of education for family planning.

2. The material and economic limitations of lower class family living. The permissive, psychological techniques of child-rearing, so touted by middle-class intellectuals, are often impossible in a low-income setting. A middle-class child with a temper tantrum can be sent to his own room until the storm is over. When an entire family lives in two rooms, however, a screaming child cannot be isolated and must be silenced. When a husbandless woman works all day to support her family, it is next to impossible for her to avoid making more than ordinary demands on her older children. Material and financial help can do much to alleviate these conditions and enable parents to participate in programs for change. Such programs should be supplemented by research into the means for improving lives within the limitations which do exist.

3. The efficiency, limited though it may be, of lower class family patterns. We should be careful, when trying to discourage seemingly pernicious forms, to see that alternate means are available to serve their purposes. The single-parent family, for example, despite its discomforts and negative aspects for children, is economically advantageous for some women at a poverty level. Such paradoxes must give pause to advocates of programs for the arbitrary elimination of apparently deviant life patterns.

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NOTES

Effect of Job Training Activities

A total of 11,642 persons with 46,589 dependents, all former recipients of public assistance, became self-supporting during October 1963-December 1964 as the direct result of job training programs conducted in 10 States under the auspices of State and local public welfare agencies. Most of the families (11,034) had been receiving help from the program of aid to families with dependent children. State and local general assistance programs had been aiding 608 of the families. A total of $1,788,000 per month in public assistance grants was being paid to these families.

The data are based on reports received by the Bureau of Family Services from the public welfare agencies in the States. The 15 months from October 1963 through December 1964 represent the first period of significant operations by State and local public welfare agencies under the 1962 Public Welfare Amendments, which place emphasis on prevention of dependency, rehabilitation, and job training.

While the information reported is not complete and does not cover all families that have become self-supporting as the result of training, it gives an indication of the effect of training programs provided in conjunction with family social service counseling. The number of public assistance recipients becoming self-supporting is expected to grow in the months ahead as more training is built into federally aided State and local public welfare programs.

New Cooperative Research Projects

Grants totaling $292,753 for nine research projects on aspects of economic dependency and social security were awarded in June 1965 under the Cooperative Research and Demonstration Grants Program of the Welfare Administration and the Social Security Administration.

Included was a grant of $67,356 to the Michigan Health and Social Security Research Institute, Detroit, to study the uses made of lump-sum and monthly benefits paid to the survivors of deceased workers in the automobile industry and the adjustments made by these families.

The University of Wisconsin was awarded $59,167 for a study of relationships between the timing of retirement and changes in the levels and sources of income.

Western Reserve University in Cleveland was awarded $43,715 for a study of how community agencies coordinate their activities for an all-out attack upon a social problem. The Cleveland project to prevent and control juvenile delinquency will be the program studied.

The Hospital and Welfare Board of Hillsborough County (Florida) was awarded $37,990 for a project designed to enhance the work skills of unemployed fathers.

Grants were also made to:

The University of Michigan ($17,720) for a study of professionalization of social welfare occupations;

The University of Massachusetts ($16,066) for an exploratory study of the varying patterns of intrafamily communication in different social and economic environments;

Columbia University ($12,000) for a study of problems involved in collecting research data from low-income populations;

Duke University ($11,600) for a study of early retirement trends and use of nonworking time in Western European countries.

Iowa State University ($10,000) for a pilot study to determine the uses made of public assistance grants and to estimate the value of various sources of non-money income to families receiving assistance;

The University of Kentucky ($9,649) to complete a study of the impact of public welfare programs in Eastern Kentucky; and

Florida State University ($7,580) for an analysis of the relationships between education and earnings of nonwhites in the United States over the past 20 years.

Child Abuse Laws

A total of 46 States now have laws on the reporting of physically abused children. The 1965 legislatures passed 25 new child abuse statutes, and four legislatures revised previously enacted statutes. Six of these States (Alaska, Missouri, New Mexico, North Carolina, Texas, and Washington) enacted permissive rather than mandatory reporting legislation. All the 1965 statutes provide immunity from liability to those reporting under the law.

Five years ago, only one State had a child abuse law. Now only Alabama, Hawaii, Mississippi, Virginia, and the District of Columbia do not have one. To help States develop child abuse laws, the Children's Bureau 2 years ago published a guide for legislation on reporting of the abused child.

The Children's Bureau is now working with the States to develop a method for obtaining statistical data on the incidence of child abuse. Such information would be important in helping communities take steps to assure that battered children get the help they need from child welfare agencies and other services.

Child Welfare Training Grants

In the third annual series of child welfare training grants administered by the Children's Bureau, 63 schools of social work and three other educational institutions were awarded more than $3 1/2 million to help train professionally qualified child welfare workers. The total of $3,578,579 awarded during fiscal year 1965 was twice the amount awarded in 1964.

Of the total awards, $1,799,155 will be used by the colleges and universities to provide 535 traineeships at the master's degree level and 28 traineeships at the doctoral level. The schools will select promising graduate students for these traineeships.

To expand and strengthen educational resources and to encourage curriculum experimentation and innovation in schools of social work, $1,550,679 was awarded for 106 teaching grants.

The awards also include 26 grants totaling $228,745 for short-term training of persons already working in the field of child welfare.

It is estimated that at least 21,000 additional child welfare workers will be needed by 1970 to staff programs which serve the social needs of children.

Publications of Interest*

WELFARE ADMINISTRATION

CHARACTERISTICS OF STAFF DEVELOPMENT PROVISIONS IN STATE PUBLIC ASSISTANCE AND CHILD WELFARE SERVICES PLANS UNDER THE SOCIAL SECURITY ACT. 1964 edition. Bureau of Family Services and Children's Bureau, 1965. 148 pp. $1. Provisions in effect on June 30, 1964, in each State, systematically presented.

COMMUNITY PLANNING IN THE PUBLIC ASSISTANCE PROGRAMS. Policies Affecting Cooperation Between Public Welfare and Health and Welfare Councils. Bureau of Family Services, 1965. 10 pp. Statement covering the legislative background, the definition of community planning used, fiscal support, the relationship with voluntary health and welfare councils.

AGING: FACT AND FANCY. By Donald P. Kent. OA No. 224. Office of Aging, 1965. 23 pp. 15 cents. Challenges common assumptions that interfere with realistic assessment of the problems of the aged.

FEDERAL ASSISTANCE FOR PROJECTS IN AGING: Training Programs of the National Institute of Mental Health, Public Health Service. OA No. 708. Office of Aging, July 1965. 12 pp. Brief description of the objectives, types of training supported, eligible applicants.

FILMS ON AGING. Selected References on Aging series. Office of Aging, June 1965. 43 pp. Also includes annotated lists of film strips, plays, film catalogs.

OTHER PUBLICATIONS

THE DEVELOPMENT OF THEORY AND PRACTICE IN SOCIAL CASEWORK. By Nina R. Garton and Herbert A. Otto. Thomas, Springfield, Ill., 1964. 181 pp. $6.75. How social casework developed, from the late 1800's through the early 1960's.

CASEBOOK ON FAMILY DIAGNOSIS AND TREATMENT. Family Service Association of America, New York, 1965. $3.50. Seven cases from family agency practice with an introduction presenting theories and concepts and a case reading guide.

CRISIS INTERVENTION: SELECTED READINGS. Edited by Howard J. Parad. Family Service Association of America, 1965. 368 pp. $4.50.

EXTENSION HOME ECONOMICS: HOW IT WORKS. Federal Extension Service, U.S. Department of Agriculture, 1965. Explains briefly the programs provided by extension home economists.

FROM KITCHEN TO CAREER. By Adele Lewis and Edith Bobroff. Bobbs-Merrill, Indianapolis, Ind., 1965. 204 pp. $3.95. Advice on how older women seeking employment should go about it.

FAMILY MOBILITY IN OUR DYNAMIC SOCIETY. Center for Agricultural and Economic Development, Iowa State University. Iowa State University Press, Ames, 1965. 283 pp. $4.95. Papers from a conference considering the adjustment problems and processes of families brought about by changing agricultural, economic, and social conditions.

SOCIAL CHANGE. By Richard T. La Piere. McGraw-Hill, New York, 1965. 556 pp. $9.50. Systematic analysis of the processes of social change.

BIBLIOGRAPHY ON COMMUNITY ORGANIZATION FOR CITIZEN PARTICIPATION IN VOLUNTARY DEMOCRATIC ASSOCIATIONS. By Richard H. P. Mendes. President's Committee on Juvenile Delinquency and Youth Crime, June 1965. 98 pp. Includes lists of works on the techniques and the theoretical and empirical foundations of community organization and on the characteristics of citizen participation.

POVERTY IN AMERICA: A BOOK OF READINGS. Edited by Louis A. Ferman, Joyce, L. Kornbluh, and Alan Haber. Introduction by Michael Harrington. University of Michigan Press, Ann Arbor, 1965. 512 pp. $9 clothbound, $5.25 paperback. Collection of articles and statements concerning the forms of poverty and the policies and programs for attacking it.

POVERTY IN AFFLUENCE. The Social, Political, and Economic Dimensions of Poverty in the United States. Harcourt, New York, 1965. 274 pp. $2.45. Collection of writings on the causes, forms, and results of poverty, and proposals for its abolition.

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*U. S. Government publications for which prices are listed may be ordered from the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. 20402 (25 percent discount on lots of 100 or more). Inquiries or orders for other publications should be directed to the publisher or issuing agency.

SPANISH HARLEM. By Patricia Cayo Sexton. Harper, New York, 1965. 208 pp. $4.95. Analyzes the poverty of Harlem--slum housing, congestion, illiteracy, and the adjustment of the rural migrant to urban living.

NEW PERSPECTIVES ON POVERTY. Edited by Arthur B. Shostak and William Gomberg. Prentice-Hall, Englewood Cliffs, N.J., 1965. 185 pp. $1.95. Focus on urban problems and reform proposals.

APPLIED SOCIOLOGY: OPPORTUNITIES AND PROBLEMS. Edited by Alvin W. Gouldner and S. M. Miller. Free Press, New York, 1965. 466 pp. $7.95. How industry, labor, government, social service agencies, and others can utilize the principles, methods, results of sociology.

FACT AND THEORY IN SOCIAL SCIENCE. Edited by Earl W. Count and Gordon T. Bowles. Syracuse University Press, Syracuse, N.Y., 1964. 253 pp. $5.50.

MATHEMATICAL FOUNDATIONS FOR SOCIAL ANALYSIS. By Robert McGinnis. Bobbs-Merrill, Indianapolis, 1965. 407 pp. $8.50.

SOCIETY AND THE ADOLESCENT SELF-IMAGE. By Morris Rosenberg. Princeton University Press, Princeton, N.J., 1965. 326 pp. $6.50. Survey of 5,000 high school students.

ADOLESCENT DEVELOPMENT AND ADJUSTMENT. By Lester D. and Alice Crow. 2d ed. McGraw-Hill, New York, 1965. 523 pp. $7.95.

SERVING THE TEENAGE GIRL. National Federation of Settlements and Neighborhood Centers, New York, 1964. 98 pp. $1.50. Focuses on the crises of adolescent girls of the lower classes.

GIRLS AT VOCATIONAL HIGH: AN EXPERIMENT IN SOCIAL WORK INTERVENTION. By Henry J. Meyer and others. Russell Sage, New York, 1965. 225 pp. $5. Report of a 6-year experimental program.

JUVENILE GANGS. By Gilbert Geis. President's Committee on Juvenile Delinquency and Youth Crime, June 1965. 60 pp. Reviews findings and theories on gangs.

VENTURES IN CRIMINOLOGY: SELECTED RECENT PAPERS. By Sheldon Glueck and Eleanor Glueck. Harvard University Press, Cambridge, 1964. 373 pp. $10. Includes a number of papers on juvenile delinquency.

CORRECTION IN THE COMMUNITY: ALTERNATIVES TO INCARCERATION. State of California Youth and Adult Corrections Agency, Sacramento, 1964. 64 pp. $1. Collection of papers on recent efforts to develop alternatives to conventional institutional confinement for delinquents.

READINGS IN THE ADMINISTRATION OF INSTITUTIONS FOR DELINQUENT YOUTH. Edited by William E. Amos and Raymond L. Manella. Thomas, Springfield, Ill., 1965. 212 pp. $7.50.

CHILD GUIDANCE. Lawson G. Lowrey Memorial Volume. Edited by Simon H. Tulchin. American Orthopsychiatric Association, New York, 1964. 380 pp. $7. Collection of papers which appeared in the American Journal of Orthopsychiatry from 1930 through 1957.

MOTHER AND BLIND CHILD. By Sadako Imamura. American Foundation for the Blind, New York, 1965. Research Series No. 14. 78 pp. $1.50. Describes the influence of child-rearing practices on the behavior of preschool blind children.

PERSPECTIVES IN AGING. Edited by Joseph T. Freeman and Irving L. Webber. A supplement to the periodical GERONTOLOGIST, March 1965. $1.25. Historical development in medical, social welfare, psychological, and other aspects.

ADVANCES IN GERONTOLOGICAL RESEARCH. Edited By Bernard L. Strehler. Vol. 1. Academic Press, New York, 1964. 410 pp. $10. Primary emphasis on the biological bases of the aging process.

NCOA JOURNAL. National Council on Aging, New York. New bimonthly on current issues and activities in the field of aging. Yearly subscription a service to members, $5 to nonmembers.

TWO-YEAR PROGRESS REPORT: JOINT TASK FORCE ON HEALTH, EDUCATION, WELFARE SERVICES AND HOUSING. By I. Jack Fasteau and Abner D. Silverman. Department of Health, Education, and Welfare and Housing and Home Finance Agency, 1964. 79 pp. Describes the approaches being used to make a program of concerted services readily available to residents of public housing.

GUIDE TO MEDICAL CARE ADMINISTRATION, VOLUME I: CONCEPTS AND PRINCIPLES. American Public Health Association, New York, 1965. 106 pp. $2. Intended to provide a unified concept of medical care and a set of principles for medical care administration. Directed toward all persons with responsibility for assuring the adequacy of personal health services. Includes glossary of terms frequently used in this field and a chronological table of major events in the history of medical care in the United States.

Program and Operating Statistics

PUBLIC ASSISTANCE IN JUNE 1965 AND FISCAL YEAR SUMMARY

In June 1965, about 8.1 million persons were receiving aid under the six public assistance programs[1]--265,000 more than in June 1964. The year's peak of more than 8.3 million was reached in March. Decreases in April-June, which totaled 178,000 persons, resulted primarily from improved economic conditions.

About 24,000 of the year's increase represented net additions under 7 new programs of medical assistance for the aged. California contributed 102,000 persons to the national increase. Contributing factors in that State were the increase under the State's relatively new unemployed-parent segment of aid to families with dependent children, liberalization of eligibility requirements for disabled persons, and the high rate of population growth between January 1963 and January 1965, which was two and one-half times that for all other States combined.

Total expenditures for assistance in the fiscal year, including vendor payments for medical care, amounted to $5,309 million--$420 million more than in the preceding year. The increase reflected largely a rise of $162 million in money payments for aid to families with dependent children and an increase of $220 million in vendor payments for medical care for recipients under all programs. By program, total payments rose $11 million (0.6 percent) in old-age assistance, $140 million (36.5 percent) in medical assistance for the aged, $2 million (2.3 percent) in aid to the blind, $71 million (16.1 percent) in aid to the permanently and totally disabled, and $191 million (12.3 percent) in aid to families with dependent children. General assistance money payments declined $7 million or 2.6 percent.

Recipients of old-age assistance numbered 2.1 million in June 1965--32,900 fewer than in June 1964. Thirty-eight States reported declines for the year; 11 States had decreases of 5 percent or more. In two of the latter States, relatively large numbers of aged persons in nursing homes were transferred to newly established programs of medical assistance for the aged. Nationally, the average payment was $80 in June--an increase of $2 for the year.

In June, payments of medical assistance for the aged were made in behalf of 264,400 persons in 44 States, 77,400 more than the total a year earlier. Roughly 14,000 of the increase was accounted for by persons in two States who resided in nursing homes and were transferred from old-age assistance. The average payment was $190 in June. The 7 programs of medical assistance for the aged established during the year brought the number of such State programs to 44.

The number of persons receiving aid to the blind decreased 2,100 to 95,300 in

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[1]Data for specified types of assistance under State programs for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged are classified with data for separate State programs for old-age assistance, aid to the blind, aid to the permanently and totally disabled, or medical assistance for the aged.

June 1965, with 37 States reporting declines. The average payment was $88, compared with $84 a year earlier.

About 555,500 persons were receiving aid to the permanently and totally disabled--54,000 more than in June 1964. California's increase was 23,800 persons. Nationally, the average payment rose from $79 in June 1964 to $85 in June 1965.

Aid to families with dependent children was paid in behalf of 4.4 million persons, including 3.3 million children--5 percent more in each instance than the number 12 months earlier. Of the totals aided in June 1965, the unemployed-parent segment accounted for 388,200 persons and 261,600 children. From June 1964 to June 1965, increases in the total number of persons receiving aid to families with dependent children were reported by four-fifths of the States. The national average payment per recipient rose $1 to $34.

General assistance cases totaled 317,000 in June 1965, compared with 325,000 in June 1964; persons assisted numbered 663,000, in contrast to 708,000 a year earlier. The average payment per recipient was $31 in June 1965--$2 more than in June 1964.

During the year, State action to raise payments to or in behalf of individual recipients, in general, was limited. Two States raised the maximums on individual money payments in some programs, and a fourth of the States increased their cost standards in three or more programs. The scope of medical care services was broadened or higher fees were allowed for certain types of medical care in only a few States.

Table 1. Number of recipients of public assistance in the United States, by month, June 1964-June 1965 1/

[Except for general assistance, includes cases receiving only vendor payments for medical care]

Year and month	Old-age assistance 2/	Medical assistance for the aged 2/	Aid to the blind 2/	Aid to the permanently and totally disabled 2/	Aid to families with dependent children			General assistance 4/	
					Families	Total recipients 3/	Children	Cases	Recipients
	Number of recipients								
1964									
June	2,182,037	187,021	97,408	501,426	1,014,109	4,214,809	3,159,402	325,000	708,000
July	2,177,074	183,866	97,259	508,895	1,009,194	4,191,200	3,142,795	321,000	700,000
August	2,167,588	205,711	97,066	511,595	1,005,821	4,175,979	3,132,370	323,000	713,000
September	2,162,386	206,440	96,853	514,938	1,003,466	4,164,828	3,126,988	321,000	702,000
October	2,160,925	218,790	96,587	519,065	1,005,871	4,174,687	3,138,005	319,000	691,000
November	2,161,452	215,230	96,417	521,787	1,010,020	4,195,145	3,152,501	322,000	702,000
December	2,159,015	224,594	96,438	527,499	1,029,948	4,292,323	3,220,591	346,000	779,000
1965									
January	2,154,586	227,606	96,155	534,602	1,046,971	4,371,936	3,274,859	352,000	806,000
February	2,150,290	228,078	95,834	534,276	1,056,145	4,424,029	3,311,726	352,000	801,000
March	2,151,542	244,534	96,194	540,394	1,073,033	4,491,840	3,360,553	359,000	809,000
April	2,152,244	254,632	95,525	545,285	1,076,061	4,505,880	3,374,923	345,000	759,000
May	2,150,592	257,506	95,504	549,893	1,069,668	4,469,527	3,352,227	327,000	693,000
June	2,149,186	264,402	95,349	555,465	1,062,814	4,429,044	3,325,931	317,000	663,000
	Percentage change from previous month								
1964									
June	-0.1	+3.4	-0.2	+0.8	-0.7	-0.9	-0.8	-2.8	-5.1
July	-.2	-1.7	-.2	+1.5	-.5	-.6	-.5	-1.5	-1.2
August	-.4	+11.9	-.2	+.5	-.3	-.4	-.3	+.8	+1.9
September	-.2	+.4	-.2	+.7	-.2	-.3	-.2	-.6	-1.5
October	-.1	+6.0	-.3	+.8	+.2	+.2	+.4	-.8	-1.6
November	(5/)	-1.6	-.2	+.5	+.4	+.5	+.5	+1.1	+1.7
December	-.1	+4.4	(5/)	+1.1	+2.0	+2.3	+2.2	+7.4	+10.9
1965									
January	-.2	+1.3	-.3	+1.3	+1.7	+1.9	+1.7	+1.7	+3.5
February	-.2	+.2	-.3	-.1	+.9	+1.2	+1.1	+.2	-.7
March	+.1	+7.2	+.4	+1.1	+1.6	+1.5	+1.5	+1.9	+1.0
April	(5/)	+4.1	-.7	+.9	+.3	+.3	+.4	-3.8	-6.1
May	-.1	+1.1	(6/)	+.8	-.6	-.8	-.7	-5.4	-8.8
June	-.1	+2.7	-.2	+1.0	-.6	-.9	-.8	-2.9	-4.2

1/ All data subject to revisions 2/ Represents data for recipients of the specified type of assistance under separate State programs and under State programs for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 3/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 4/ Partly estimated. Excludes Idaho, Indiana, and Nebraska; data not available. 5/ Increase of less than 0.05 percent. 6/ Decrease of less than 0.05 percent.

Table 2. Amount of public assistance payments in the United States, by month, June 1964-June 1965 1/

[Except for general assistance, includes vendor payments for medical care]

Year and month	Total 2/	Old-age assistance 3/	Medical assistance for the aged 3/	Aid to the blind 3/	Aid to the permanently and totally disabled 3/	Aid to families with dependent children	General assistance 4/
	Amount of assistance						
1964							
June	$422,681,000	$171,135,263	$36,835,583	$8,188,807	$39,365,811	$137,028,262	$21,063,000
July	423,386,000	171,666,857	36,263,042	8,218,116	40,135,368	137,360,488	21,096,000
August	422,234,000	168,196,378	39,228,163	8,198,173	39,874,356	136,270,529	20,941,000
September	423,655,000	168,527,705	38,263,807	8,179,619	40,478,606	137,613,993	21,263,000
October	434,086,000	170,460,986	43,738,448	8,237,591	41,283,451	139,491,306	21,687,000
November	428,300,000	168,958,898	39,967,657	8,194,102	41,294,048	139,298,640	21,320,000
December	444,770,000	170,316,837	44,141,314	8,271,899	42,514,587	145,182,490	23,743,000
1965							
January	442,181,000	169,149,172	43,848,997	8,275,409	42,486,266	145,748,741	23,191,000
February	446,512,000	170,189,513	42,535,323	8,267,896	43,302,081	148,891,335	23,444,000
March	460,828,000	172,509,810	45,585,652	8,372,511	45,391,949	154,259,544	24,306,000
April	466,251,000	173,958,755	49,842,346	8,315,346	45,629,421	154,713,550	23,252,000
May	457,982,000	171,419,500	49,325,801	8,262,655	45,913,531	152,032,610	21,389,000
June	459,170,000	172,714,534	50,363,164	8,379,034	47,022,836	149,854,336	20,784,000
	Percentage change from previous month						
1964							
June	(5/)	(5/)	+4.6	-0.1	+1.0	-1.0	-3.5
July	+0.2	+0.3	-1.6	+.4	+2.0	+.2	+.2
August	-.3	-2.0	+8.2	-.2	-.7	-.8	-.7
September	+.3	+.2	-2.5	-.2	+1.5	+1.0	+1.5
October	+2.5	+1.1	+14.3	+.7	+2.0	+1.4	+2.0
November	-1.3	-.9	-8.6	-.5	(6/)	-.1	-1.7
December	+3.8	+.8	+10.4	+.9	+3.0	+4.2	+11.4
1965							
January	-.6	-.7	-.7	(6/)	-.1	+.4	-2.3
February	+1.0	+.6	-3.0	-.1	+1.9	+2.2	+1.1
March	+3.2	+1.4	+7.2	+1.3	+4.8	+3.6	+3.7
April	+1.2	+.8	+9.3	-.7	+.5	+.3	-4.3
May	-1.8	-1.5	-1.0	-.6	+.6	-1.7	-8.0
June	+.3	+.8	+2.1	+1.4	+2.4	-1.4	-2.8

1/ All data subject to revision. 2/ Total exceeds sum of columns because of inclusion of vendor payments for medical care from general assistance funds and from special medical funds; data for such expenditures partly estimated for some States. 3/ Represents data for payments to recipients of the specified type of assistance under separate State programs and under State programs for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 4/ Partly estimated. Excludes Idaho, Indiana, and Nebraska; data not available. 5/ Decrease of less than 0.05 percent. 6/ Increase of less than 0.05 percent.

Table 3. Old-age assistance: Recipients and payments to recipients, by State, June 1965 1/

[Includes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	May 1965 in--		June 1964 in--	
				Number	Amount	Number	Amount
Total 2/...	2,149,186	$172,714,534	$80.36	-0.1	+0.8	-1.5	+0.9
Ala.....	112,200	7,532,056	67.13	+.1	-1.6	+1.7	+1.7
Alaska 3/.....	1,372	4/ 134,971	98.38	0	0	-1.2	+3.9
Ariz.....	13,322	845,858	63.49	+.8	+.7	-.1	-1.1
Ark.....	59,755	3,815,910	63.86	+.5	+1.3	+2.6	+2.5
Calif.....	275,079	30,119,593	109.49	-.4	+.9	+1.2	+2.8
Colo. 2/.....	43,922	4,277,138	97.38	-.1	+3.1	-10.0	-13.8
Conn.....	6,694	669,502	100.02	-.1	+20.7	-13.3	+15.1
Del.....	1,413	101,974	72.17	+.1	+1.6	+12.9	+25.9
D. C.....	2,358	215,513	91.40	-.1	+.9	-2.0	+1.1
Fla. 3/.....	74,204	4,829,672	65.09	+.2	+1.2	+3.0	+1.0
Ga.....	92,205	5,390,922	58.47	+.2	+1.7	+.2	+3.9
Guam 5/.....	156	5,238	33.58	---	---	---	---
Hawaii 3/.....	1,196	85,845	71.78	+.2	-1.4	+3.1	-.4
Idaho.....	4,182	307,711	73.58	-1.4	+2.5	-10.2	-12.7
Ill. 3/.....	54,583	5,193,631	95.15	-1.3	-3.7	-6.5	+1.0
Ind.....	22,567	1,962,256	86.95	-.5	-4.0	-2.6	+4.5
Iowa.....	26,786	2,548,220	95.13	-.6	-1.6	-6.6	-2.8
Kans. 3/.....	21,390	2,084,287	97.44	-.6	+2.6	-2.6	+10.7
Ky. 3/.....	59,429	3,804,261	64.01	+.7	+.1	+4.7	+8.6
La.....	131,096	11,133,819	84.93	-.1	-.1	+.6	+.4
Maine 3/.....	10,857	906,779	83.52	+.1	-.1	-2.4	-3.2
Md. 3/.....	10,037	742,843	74.01	+.9	+1.0	+5.0	+6.7
Mass.....	51,804	4,817,823	93.00	-.4	+.7	-4.8	-1.9
Mich.....	48,664	5,083,864	104.47	+.4	+6.0	-2.2	+14.2
Minn.....	31,638	2,838,240	89.71	-.2	+.4	-25.1	-43.1
Miss.....	73,390	3,021,550	41.17	+.2	+3.4	-1.0	+.4
Mo.....	101,443	7,082,540	69.82	(6/)	+1.5	-2.1	+1.6
Mont.....	5,171	374,326	72.39	-.4	+.5	-4.9	-4.4
Nebr.....	12,428	1,212,343	97.55	-.3	-.3	-1.6	+4.9
Nev.....	2,670	233,389	87.41	+.3	+1.0	+4.7	+2.4
N. H.....	4,374	445,492	101.85	+.4	+.7	-1.8	-.8
N. J.....	13,939	1,238,021	88.82	-.2	-.5	-.1	+10.6
N. Mex. 3/ 7/..	10,191	790,915	77.61	---	---	---	---
N. Y. 3/.....	57,038	5,361,529	94.00	+.8	-2.5	+1.4	+3.0
N. C.....	42,817	2,695,705	62.96	(8/)	+.3	-1.8	+3.6
N. Dak. 3/.....	5,079	493,503	97.17	-.7	-2.6	-5.7	+2.3
Ohio.....	81,321	7,730,584	95.06	-.5	+7.2	-4.5	+6.7
Okla. 3/.....	82,325	7,924,081	96.25	-.1	-.2	-1.4	-.6
Oreg.....	10,116	716,159	70.79	-.4	+.4	-8.5	-5.3
Pa.....	45,921	3,609,030	78.59	-.2	-.6	-1.8	+3.7
P. R. 3/.....	29,884	284,090	9.51	-.8	-1.5	-7.0	-5.1
R. I. 3/.....	5,765	554,797	96.24	-.5	+.2	-3.2	+9.0
S. C 7/.....	25,338	1,377,247	54.36	---	---	---	---
S. Dak.....	6,952	698,143	100.42	-.5	-.3	-3.9	+14.1
Tenn.....	44,675	2,645,571	59.22	+.1	+1.8	-1.7	+11.7
Tex.....	230,845	16,190,942	70.14	+.1	-.2	+.7	+.7
Utah.....	4,733	331,491	70.04	-.2	+6.7	-6.5	-5.4
Vt. 3/.....	5,357	522,346	97.50	+.3	+11.5	-1.7	+12.6
V. I.....	450	17,289	38.42	+4.4	-1.7	-2.4	+8.9
Va.....	13,135	883,166	67.24	+.2	+2.6	-2.1	+5.2
Wash.....	32,429	2,739,248	84.47	(8/)	+2.9	-3.9	+6.0
W. Va.....	14,025	760,759	54.24	+.2	+.2	-4.4	+5.2
Wis.....	28,053	3,128,541	111.52	-.7	-3.2	-4.9	+.8
Wyo.....	2,413	203,811	84.46	-.2	-2.4	-5.0	-3.3

1/ All data subject to revision. 2/ Includes 3,812 recipients aged 60-64 in Colorado and payments of $334,288 to these recipients. Such payments were made without Federal participation. 3/ Represents aid to the aged under program for aid to the aged, blind, or disabled, or for such aid and medical assistance for the aged. 4/ In addition, supplemental payments from general assistance funds were made to recipients. 5/ Data for March; June data not received. 6/ Decrease of less than 0.05 percent. 7/ Data for May; June data not received. 8/ Increase of less than 0.05 percent.

Table 4. Medical assistance for the aged: Recipients and payments for recipients, by State, June 1965 1/

State	Number of recipients 2/	Payments for recipients		Percentage change from May 1965	
		Total amount	Average	Number	Amount
Total.....	264,402	$50,363,164	$190.48	+2.7	+2.1
Ala.....	257	81,301	316.35	-15.7	-4.4
Ark.....	3,100	190,079	61.32	+3.4	+21.0
Calif.....	31,768	9,852,195	310.13	-8.4	-8.0
Colo.....	5,671	3/ 972,211	171.44	+15.6	-2.4
Conn.....	7,421	3/ 1,445,219	194.75	+4.5	+6.5
Del.....	130	24,915	191.65	(4/)	(4/)
Dist. of Col.....	822	388,300	472.38	-.7	+48.1
Fla. 5/.....	829	278,501	335.95	-16.1	-20.3
Guam.....	(6/)	(6/)	(6/)	(6/)	(6/)
Hawaii 5/.....	540	140,175	259.58	+66.7	+115.3
Idaho.....	2,473	343,123	138.75	+1.1	+1.6
Ill. 5/.....	1,467	532,425	362.93	-9.3	-15.8
Ind.....	409	74,537	182.24	+48.7	+16.3
Iowa.....	5,169	569,010	110.08	-18.1	-26.0
Kans. 5/.....	2,933	3/ 465,010	158.54	+2.3	+7.9
Ky. 5/.....	12,545	353,444	28.17	+10.4	-38.0
La.....	619	98,501	159.13	-1.3	+1.7
Maine 5/.....	597	156,166	261.58	+65.4	+58.9
Md. 5/ 7/.....	11,620	593,589	---	---	---
Mass.....	30,451	3/ 5,508,765	180.91	+.2	+3.8
Mich.....	6,454	2,763,920	428.25	+5.3	+19.5
Minn.....	14,377	3/ 2,801,091	194.83	+2.7	+2.1
Nebr.....	331	3/ 114,177	344.95	-5.4	-18.9
N. H.....	2,260	117,413	51.95	+21.9	+34.5
N. J.....	5,402	3/ 1,228,748	227.46	-2.5	-12.2
N. Y. 5/.....	36,802	3/ 12,476,646	339.02	+.3	+8.0
N. C.....	2,110	394,276	186.86	+125.9	+57.0
N. Dak. 5/.....	8/ 1,426	3/ 331,844	232.71	+4.9	+13.1
Okla.....	1,129	159,845	141.58	-6.2	-15.2
Oreg.....	4,124	610,319	147.99	-.8	-.5
Pa.....	11,491	2,812,256	244.74	+5.2	+2.1
P. R. 5/ 7/.....	3,683	102,395	---	---	---
R. I. 5/.....	8,729	496,188	56.84	+15.7	-19.9
S. C. 9/.....	1,252	213,382	170.43	---	---
S. Dak.....	626	29,440	47.03	+1.1	+.3
Tenn.....	10,598	344,953	32.55	+7.9	+3.8
Utah.....	2,490	244,023	98.00	+6.1	+10.4
Vt. 5/.....	126	27,660	219.52	-18.2	-12.8
V. I.....	142	6,888	48.51	(4/)	(4/)
Va.....	3,549	251,127	70.76	+12.4	+11.8
Wash.....	10,390	1,520,885	146.38	+1.9	+6.1
W. Va.....	11,075	291,252	26.30	+10.7	+4.3
Wis.....	6,969	925,879	132.86	+15.7	+22.9
Wyo.....	46	31,091	(4/)	(4/)	(4/)

1/ All data subject to revision. 2/ Persons for whom vendor payments were made during the report month. 3/ Includes money payments not subject to Federal participation as follows: $26,231 in Colorado, $22 in Connecticut, $11,986 in Kansas, $97,083 in Massachusetts, $35,698 in Minnesota, $48 in Nebraska, $8,382 in New Jersey, $50,182 in New York, and $2,847 in North Dakota. 4/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients. 5/ Represents medical assistance for the aged under program for aid to the aged, blind, or disabled and medical assistance for the aged. 6/ Data not reported. 7/ Estimated. 8/ Includes an unknown number of cases receiving only money payments. 9/ Data for May; June data not received.

Table 5. Aid to the blind: Recipients and payments to recipients, by State, June 1965 1/

/Includes vendor payments for medical care and cases receiving only such payments/

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	May 1965 in--		June 1964 in--	
				Number	Amount	Number	Amount
Total 2/....	95,349	$8,379,034	$87.88	-0.2	+1.4	-2.1	+2.3
Ala.....	1,845	126,892	68.78	+.4	+.2	+4.8	+11.4
Alaska 3/.....	111	9,312	83.89	0	0	+4.7	+12.9
Ariz.....	818	58,628	71.67	+.5	+.8	-1.7	-2.9
Ark.....	1,942	137,150	70.62	+.7	+1.8	-.9	-1.1
Calif 2/.....	12,398	1,799,548	145.15	-.7	+8.7	-1.3	+10.8
Colo.....	249	21,764	87.41	-2.7	-1.9	-4.6	-6.0
Conn.....	309	41,718	135.01	+2.7	+25.1	-.6	+22.5
Del.....	314	25,935	82.60	+1.6	-2.6	+2.6	+4.8
D. C.....	204	15,997	78.42	-.5	+4.4	+1.0	+8.9
Fla. 3/.....	2,590	176,151	68.01	-.2	+2.7	+.3	+2.0
Ga.....	3,189	193,528	60.69	+.2	+.1	+.2	+3.8
Guam 4/.....	7	235	(5/)	---	---	---	---
Hawaii 3/.....	73	6,980	95.62	(5/)	(5/)	(5/)	(5/)
Idaho.....	132	9,495	71.93	-.8	-3.1	0	-3.4
Ill. 3/.....	2,392	231,115	96.62	-.8	-2.6	-6.2	+.5
Ind.....	1,758	155,916	88.69	-.3	-2.9	-.3	+6.5
Iowa.....	1,131	116,109	102.66	-.2	+.4	-5.0	-4.9
Kans. 3/.....	503	50,834	101.06	0	+3.5	+.6	+10.9
Ky. 3/.....	2,504	186,775	74.59	+.6	+3.4	+2.9	+8.7
La.....	2,755	224,096	81.34	(6/)	(7/)	-2.6	-3.4
Maine 3/.....	301	26,024	86.46	+1.0	+2.5	-11.2	-9.3
Md. 3/.....	392	31,750	80.99	+.8	-.3	-1.3	-.9
Mass.....	2,237	306,871	137.18	-1.4	-8.5	-1.7	+1.5
Mich.....	1,667	157,146	94.27	+.7	+3.3	-1.0	+8.4
Minn.....	1,056	118,503	112.22	+1.5	-4.5	-3.4	-17.6
Miss.....	2,580	118,402	45.89	-.4	+2.4	-11.0	-12.0
Mo. 2/.....	4,349	326,175	75.00	-.4	-.4	-4.9	-4.9
Mont.....	241	21,214	88.02	-.8	+3.3	-2.0	+.9
Nebr.....	622	65,818	105.82	-1.1	+1.0	-4.5	-4.8
Nev.....	159	18,909	118.92	0	+.9	-3.6	-6.0
N. H.....	260	28,134	108.21	0	+1.4	-.8	+2.5
N. J.....	922	81,752	88.67	+.3	-4.6	-3.7	+1.1
N. Mex. 3/ 8/...	347	32,617	94.00	---	---	---	---
N. Y. 3/.....	3,185	371,608	116.67	+1.7	-1.2	(6/)	+3.6
N. C.....	4,927	345,849	70.19	-.1	-.7	-2.8	+.6
N. Dak. 3/.....	81	7,517	92.80	(5/)	(5/)	(5/)	(5/)
Ohio.....	3,260	270,633	83.02	-.4	-.1	-2.6	-.7
Okla. 3/.....	1,618	197,818	122.26	-.6	-1.0	-3.6	-3.0
Oreg.....	469	42,009	89.57	+1.3	-2.9	+11.7	+20.1
Pa. 2/.....	17,527	1,329,315	75.84	-.3	-.1	-2.0	-.7
P. R. 3/.....	1,374	12,090	8.80	-.4	+.9	-8.0	-4.1
R. I. 3/.....	106	9,978	94.13	+1.0	-4.7	(5/)	(5/)
S. C. 3/.....	1,866	119,762	64.18	---	---	---	---
S. Dak.....	112	7,667	68.46	0	-1.1	-7.4	-7.5
Tenn.....	2,060	115,029	55.84	-1.1	-2.5	-6.2	(6/)
Tex.....	4,671	325,366	69.66	-.5	-.5	-2.7	-2.3
Utah.....	167	12,595	75.42	-.6	+3.2	-1.8	-5.9
Vt. 3/.....	120	9,453	78.78	+2.6	+8.8	+6.2	-4.5
V. I.....	10	360	(5/)	(5/)	(5/)	(5/)	(5/)
Va.....	1,140	82,664	72.51	+.2	+3.6	+.4	+4.8
Wash.....	670	62,317	93.01	+1.4	-.1	-1.5	+4.7
W. Va.....	780	44,955	57.63	-.1	+.3	-4.8	+14.1
Wis.....	793	85,234	107.48	+.5	+1.4	-2.1	+3.0
Wyo.....	56	5,322	95.04	(5/)	(5/)	(5/)	(5/)

1/ All data subject to revision. 2/ Data include recipients of payments made without Federal participation and payments to these recipients as follows: California, $15,691 to 88 recipients; Missouri, $52,853 to 695 recipients; and Pennsylvania, $950,541 to 12,805 recipients. 3/ Represents aid to the blind under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 4/ Data for March; June data not received. 5/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients. 6/ Decrease of less than 0.05 percent. 7/ Increase of less than 0.05 percent. 8/ Data for May; June data not received.

Table 6. Aid to the permanently and totally disabled: Recipients and payments to recipients, by State, June 1965 1/

[Includes vendor payments for medical care and cases receiving only such payments]

State	Number of recipients	Payments to recipients		Percentage change from--			
		Total amount	Average	May 1965 in--		June 1964 in--	
				Number	Amount	Number	Amount
Total.....	555,465	$47,022,836	$84.65	+1.0	+2.4	+10.8	+19.4
Ala.....	14,955	692,955	46.34	+.4	-.8	+3.0	+3.4
Alaska 2/.....	217	36,248	167.04	0	0	+36.5	+29.9
Ariz.....	3,752	252,525	67.30	+2.6	+2.6	+28.4	+28.5
Ark.....	9,620	595,201	61.87	+.4	+3.5	+4.1	+8.9
Calif.....	73,125	8,605,284	117.68	+2.8	+4.0	+48.2	+54.6
Colo.....	6,145	488,965	79.57	+.3	+1.6	+1.7	+4.0
Conn.....	8,474	767,632	90.59	+1.2	+17.3	+18.4	+57.1
Del.....	444	33,989	76.55	0	-2.0	+3.0	+7.3
Dist. of Col....	3,323	276,222	83.12	+1.0	+2.0	+8.2	+14.0
Fla. 2/.....	17,711	1,213,493	68.52	+.7	+1.8	+9.6	+5.3
Ga.....	27,035	1,662,471	61.49	+.2	+2.1	+3.2	+6.6
Guam 3/.....	44	1,332	(4/)	---	---	---	---
Hawaii 2/.....	1,216	142,741	117.39	+12.3	+20.9	+16.0	-6.8
Idaho.....	3,084	176,965	57.38	-1.3	-.4	+9.9	+9.6
Ill. 2/.....	29,877	3,030,562	101.43	+.6	-.3	+6.3	+15.9
Ind.....	1,610	218,409	135.66	+1.6	+19.7	+44.3	+68.3
Iowa.....	1,284	107,036	83.36	0	-.1	+13.1	+13.8
Kans. 2/.....	5,102	584,955	114.65	+.3	-.6	+10.7	+21.6
Ky. 2/.....	11,467	896,004	78.14	+1.3	+1.4	+15.5	+20.0
La.....	19,662	1,155,045	58.75	+.6	+.3	+4.2	+4.6
Maine 2/.....	2,263	204,498	90.37	0	-.4	+1.5	+4.6
Md. 2/.....	7,966	689,482	86.55	+.7	+1.3	+7.6	+19.6
Mass.....	13,255	2,009,369	151.59	+.9	-3.0	+11.8	+17.7
Mich.....	11,980	1,377,960	115.02	+6.0	+14.2	+58.2	+69.2
Minn.....	3,920	240,450	61.34	+.3	+.4	+12.7	+13.1
Miss.....	19,080	837,688	43.90	+.7	+.6	+9.6	+10.5
Mo.....	15,334	1,115,503	72.75	+.6	+.7	+4.4	+8.3
Mont.....	1,369	108,327	79.13	+.7	+1.2	+7.0	+7.9
Nebr.....	2,725	266,917	97.95	+.5	-2.1	+10.2	+15.8
N. H.....	623	73,825	118.50	+.2	+25.6	+7.6	+10.8
N. J.....	8,806	893,164	101.43	-.2	+.5	+5.0	+11.7
N. Mex. 2/ 5/...	3,868	349,055	90.24	---	---	---	---
N. Y. 2/.....	36,236	4,881,599	134.72	+1.1	+2.4	+2.5	+7.6
N. C.....	22,852	1,763,886	77.19	+.5	+2.2	+4.0	+11.1
N. Dak. 2/.....	1,732	230,942	133.34	+1.3	+5.8	+18.3	+37.7
Ohio.....	19,747	1,552,316	78.61	+1.2	+1.0	+5.4	+12.3
Okla. 2/.....	14,688	1,648,417	112.23	+.7	+.6	+11.5	+13.0
Oreg.....	8,209	560,459	68.27	+.5	-.4	+5.6	+13.3
Pa.....	20,954	1,624,671	77.54	(6/)	+.1	+6.5	+15.4
P. R. 2/.....	20,651	189,156	9.16	-.6	+3.4	-3.0	+2.3
R. I. 2/.....	2,899	278,706	96.14	+1.1	+.9	+5.0	+10.9
S. C. 5/.....	9,002	490,890	54.53	---	---	---	---
S. Dak.....	1,112	78,039	70.18	-.6	-.3	+.9	+1.5
Tenn.....	13,565	747,580	55.11	+.7	+.9	+7.6	+16.6
Tex.....	9,981	570,253	57.13	+.5	+.5	+7.4	+7.2
Utah.....	4,964	333,095	67.10	+1.7	+2.0	+4.7	+.9
Vt. 2/.....	1,282	111,352	86.86	+2.3	+14.3	+18.0	+22.1
V. I.....	56	2,161	38.59	(4/)	(4/)	(4/)	(4/)
Va.....	6,909	490,609	71.01	+.4	+1.3	+2.6	+9.4
Wash.....	18,383	1,210,285	65.84	+1.4	+9.7	-.2	+16.0
W. Va.....	5,814	309,736	53.27	(6/)	+.2	-5.0	-1.8
Wis.....	6,388	785,659	122.99	+.4	+2.3	+8.8	+17.8
Wyoming.....	705	58,753	83.34	+1.3	+5.2	+15.4	+15.3

1/ All data subject to revision. 2/ Represents aid to the permanently and totally disabled under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 3/ Data for March; June data not received. 4/ Average payment not computed on fewer than 50 recipients; percentage change on fewer than 100 recipients. 5/ Data for May; June data not received. 6/ Increase of less than 0.05 percent.

Table 7. Aid to families with dependent children: Recipients and payments to recipients, by State, June 1965 1/

/Includes vendor payments for medical care and cases receiving only such payments/

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
					Average per--		May 1965 in--		June 1964 in--	
		Total 2/	Children	Total amount	Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total.....	1,062,814	4,429,044	3,325,931	$149,854,336	$141.00	$33.83	-0.9	-1.4	+5.1	+9.4
Ala. 3/.....	18,104	73,954	58,516	873,172	48.23	11.81	-.9	-1.1	-19.7	-19.0
Alaska 3/.....	1,320	4,884	3,740	170,280	129.00	34.86	0	0	+4.7	+4.3
Ariz. 3/.....	9,453	40,737	30,702	1,169,587	123.73	28.71	-.7	-.5	-2.2	-3.4
Ark.....	7,453	31,401	23,694	530,141	71.13	16.88	-.9	+.1	+7.7	+7.5
Calif. 3/ 4/...	138,439	566,097	418,723	24,380,833	176.11	43.07	-2.2	-3.4	+16.3	+16.2
Colo.....	11,298	44,036	34,160	1,666,811	147.53	37.85	+.4	+.7	+8.2	+13.0
Conn. 4/.....	14,795	59,561	43,595	2,881,191	194.74	48.37	+.6	+5.2	+4.3	+16.3
Del. 4/.....	2,612	11,662	8,886	332,439	127.27	28.51	-4.8	-4.4	+7.2	+10.2
D. C.....	4,441	21,253	17,151	693,966	156.26	32.65	+1.0	+1.0	+11.2	+11.3
Fla.....	27,907	107,851	86,387	1,690,992	60.59	15.68	(5/)	-.1	+4.5	+2.3
Ga.....	18,572	74,757	57,343	1,655,390	89.13	22.14	-1.6	-1.6	+16.5	+16.0
Guam 6/.....	131	674	560	10,867	82.95	16.12	---	---	---	---
Hawaii 4/.....	3,166	13,632	10,125	480,565	151.79	35.25	-1.7	+.7	+.4	-5.3
Idaho.....	2,622	10,082	7,363	390,834	149.06	38.77	-2.7	-2.4	+2.1	+4.6
Ill. 3/ 4/.....	55,606	261,896	202,198	11,766,539	211.61	44.93	-1.6	-3.1	-.2	+2.7
Ind. 3/.....	12,000	49,017	36,691	1,453,638	121.14	29.66	-.7	-.6	+.9	+.5
Iowa.....	11,364	45,658	33,237	1,776,946	156.37	38.92	+.8	-.5	+9.4	+10.6
Kans. 3/ 4/....	9,041	38,294	29,361	1,484,491	164.20	38.77	-1.6	-3.4	+13.6	+17.8
Ky. 3/.....	21,474	83,931	60,321	2,144,704	99.87	25.55	+.5	-3.8	+8.0	+10.4
La. 3/.....	24,050	105,393	80,104	2,432,890	101.16	23.08	-.7	-1.7	+3.7	+3.9
Maine.....	5,197	18,992	13,952	547,827	105.41	28.85	-.5	-.7	-4.0	-4.6
Md. 3/ 4/.....	20,184	85,511	65,984	2,887,697	143.07	33.77	+.3	+.7	+21.2	+25.3
Mass. 4/.....	26,122	98,614	73,994	4,705,043	180.12	47.71	-.4	+.2	+9.6	+10.3
Mich. 3/ 4/....	40,035	163,551	121,074	5,944,036	148.47	36.34	-2.1	-1.6	+2.8	+6.6
Minn. 3/.....	14,513	53,149	41,403	2,779,551	191.52	52.30	+.1	+.6	+10.9	+10.4
Miss.....	20,784	83,533	66,948	762,767	36.70	9.13	+.2	+.5	+.8	-13.2
Mo. 3/.....	26,446	108,447	83,067	2,636,181	99.68	24.31	-.4	-.8	+1.7	+2.3
Mont.....	1,867	7,518	5,834	274,323	146.93	36.49	-.4	+.8	+5.5	+9.3
Nebr.....	4,207	17,138	13,175	544,796	129.50	31.79	+.1	-.5	+14.0	+19.8
Nev.....	1,302	5,332	4,205	167,575	128.71	31.43	-1.2	-.8	+11.6	+10.8
N. H.....	1,142	4,719	3,533	206,438	180.77	43.75	-.4	+.2	+8.8	+10.7
N. J.....	27,683	109,682	83,203	5,518,767	199.36	50.32	+.5	+.2	+9.5	+13.9
N. Mex. 3/ 7/..	7,150	29,539	22,524	975,280	136.40	33.02	---	---	---	---
N. Y. 4/.....	125,764	540,253	396,540	25,636,253	203.84	47.45	+.6	-.3	+10.3	+17.7
N. C. 3/.....	27,326	113,589	84,833	2,889,592	105.75	25.44	-.4	+1.1	-.7	+4.3
N. Dak.....	2,094	8,378	6,394	382,058	182.45	45.60	+.9	-.9	+15.2	+25.1
Ohio 4/.....	46,054	195,685	145,454	6,110,791	132.69	31.23	-1.5	3.2	+15.4	+17.5
Okla. 3/ 4/....	18,773	74,529	55,452	2,475,729	131.88	33.22	+.1	-.1	+.9	-3.3
Oreg. 3/ 4/....	8,265	32,547	24,023	1,263,641	152.89	38.83	-2.6	-3.3	+10.6	+12.6
Pa. 4/.....	65,817	289,312	209,384	9,061,882	137.68	31.32	-2.1	-3.1	-7.7	-3.2
P. R.....	48,589	196,912	157,425	813,626	16.75	4.13	-.9	(8/)	-4.4	-4.6
R. I. 4/.....	5,895	23,572	17,437	982,785	166.72	41.69	-1.2	-.7	+1.0	+4.3
S. C 7/.....	7,344	29,359	23,627	468,790	63.83	15.97	---	---	---	---
S. Dak.....	3,065	11,516	8,668	370,283	120.81	32.15	-.4	+.6	+13.1	+18.6
Tenn. 3/.....	19,376	77,857	59,380	1,748,427	90.24	22.46	+.1	(8/)	+1.9	+14.3
Tex.....	20,625	93,989	70,953	1,758,658	85.27	18.71	-1.3	-1.1	+8.6	+13.7
Utah 3/ 4/.....	5,598	23,305	16,521	749,361	133.86	32.15	+2.2	+5.1	+14.6	+13.3
Vt.....	1,484	5,651	4,136	167,789	113.07	29.69	+.3	+.3	+3.9	+3.2
V. I.....	295	1,039	887	20,854	70.69	20.07	-8.4	-1.7	-10.1	+6.4
Va. 3/.....	10,805	46,001	35,505	1,162,441	107.58	25.27	-1.9	-1.7	+2.3	+7.1
Wash. 3/ 4/....	18,542	74,207	52,881	2,608,972	140.71	35.16	-2.2	(5/)	+14.7	+8.3
W. Va. 3/ 4/...	24,413	112,671	78,223	3,009,847	123.29	26.71	-2.6	-2.7	-5.3	-5.6
Wis. 3/.....	11,225	44,366	33,506	2,088,168	186.03	47.07	-2.2	-5.2	-1.5	+1.0
Wyo.....	985	3,811	2,949	147,832	150.08	38.79	+.3	-.2	+13.7	+17.9

1/ All data subject to revision. 2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 3/ Includes data on foster-family care; see table 10. 4/ Includes data on unemployed-parent segment; see table 8. 5/ Increase of less than 0.05 percent. 6/ Data for March; June data not received. 7/ Data for May; June data not received. 8/ Decrease of less than 0.05 percent.

Table 8. Aid to families with dependent children, unemployed-parent segment: Recipients and payments to recipients, June 1965 1/

/Includes vendor payments for medical care and cases receiving only such payments/

State	Number of families	Number of recipients		Payments to recipients			Percentage change from--			
		Total 2/	Children	Total	Average per--		May 1965 in--		June 1964 in--	
					Family	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total.....	66,517	388,244	261,602	$12,008,180	$180.53	$30.93	-9.7	-12.8	+0.6	+2.0
Calif.....	14,580	86,086	58,343	2,743,589	188.17	31.87	-13.2	-20.6	+48.2	+44.6
Conn.....	1,694	9,865	6,576	262,787	155.13	26.64	-3.6	-11.1	-19.6	-32.4
Del.....	222	1,304	892	35,000	157.66	26.84	-23.9	-23.8	-36.8	-36.6
Hawaii....	253	1,610	1,106	46,603	184.20	28.95	-7.2	-8.5	-19.3	-21.9
Ill.....	5,625	36,340	25,332	1,497,465	266.22	41.21	-9.8	-10.3	-20.8	-19.2
Kans.....	394	2,416	1,641	85,560	217.16	35.41	-20.8	-21.1	+24.0	+50.1
Mi.....	348	2,053	1,377	59,138	169.94	28.81	-13.7	-12.2	-19.9	-18.0
Mass.....	660	3,649	2,449	159,275	241.33	43.65	-5.9	-8.6	-1.0	+21.9
Mich.....	3,143	19,635	13,506	622,787	198.15	31.72	-18.5	-18.2	-19.6	-12.3
N. Y.....	14,812	85,823	58,271	2,867,115	193.57	33.41	-5.7	-7.6	-1.1	+4.9
Ohio.....	4,919	28,293	19,054	790,478	160.70	27.94	-10.5	-14.5	+135.3	+129.8
Okla.....	21	138	99	3,568	(3/)	(3/)	-26.6	-31.1	-6.8	-11.7
Oreg.....	920	5,105	3,569	177,210	192.62	34.71	-13.1	-14.4	+34.5	+25.0
Pa.....	5,513	31,455	20,853	695,379	126.13	22.11	-8.9	-16.5	-38.4	-41.6
R. I.....	356	2,192	1,496	73,600	206.74	33.58	-11.4	-11.1	-3.38	-35.5
Utah.....	994	5,440	3,597	109,234	109.89	20.08	-2.1	+4.5	+14.5	+11.5
Wash.....	2,514	14,019	9,078	345,452	137.41	24.64	-15.6	-9.0	+13.5	+4.6
W. Va.....	9,549	52,821	34,363	1,433,940	150.17	27.15	-4.7	-4.8	-10.1	-10.1

1/ Data for this segment of the program, shown separately here, are included in data for the total program. All data subject to revision. 2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 3/ Average payment not computed on base of fewer than 50 families.

Table 9. Aid to families with dependent children: Recipients and money payments to recipients under community work and training programs, by State, June 1965 1/

State	Number of families with an adult on work and training programs	Number of recipients				Money payments to recipients			
		Total 2/	Adults		Children	Total	For work performed on work and training programs	Average per family	
			On work and training programs	Other				Total	For work performed on work and training programs
Total.....	21,490	121,537	21,503	19,041	80,993	$4,129,422	$2,849,814	$192.16	$132.61
California.....	5,328	29,858	5,339	4,325	20,194	1,552,111	480,323	291.31	90.15
Illinois.....	2,097	12,899	2,099	1,827	8,973	434,252	359,175	207.08	171.28
Kansas.....	97	563	97	93	373	25,927	9,740	267.29	100.41
Maryland.....	111	633	111	109	413	19,574	12,733	176.34	114.71
Michigan.....	(3/)	(3/)	(3/)	(3/)	(3/)	(3/)	(3/)	(3/)	(3/)
Ohio.....	3,249	18,689	3,249	2,744	12,696	675,042	614,283	207.77	189.07
Oregon.....	106	597	106	81	410	23,131	10,407	218.22	98.18
Pennsylvania.....	623	3,667	623	623	2,421	110,111	77,642	176.74	124.63
Washington.....	330	1,810	330	330	1,150	53,400	49,637	161.82	150.42
West Virginia.....	9,549	52,821	9,549	8,909	34,363	1,235,874	1,235,874	129.42	129.42

1/ Represents data for community work and training programs under plans for such programs submitted under Section 409 of Social Security Act. 2/ Includes as recipients the children and 1 or both parents or 1 caretaker relative other than a parent in families in which the requirements of such adults were considered in determining the amount of assistance. 3/ Data not reported.

Table 10. Aid to families with dependent children receiving foster care: Recipients and payments for foster care, by State, June 1965 1/

State	Number of				Payments for foster care			
	Children receiving foster care			Families from which children were removed	Total amount	Average per child	In foster homes	In institutions
	Total	In foster homes	In institutions					
Total.....	5,779	2/ 5,138	2/ 303	2,415	$403,624	$69.84	2/ $330,490	2/ $44,888
Ala.....	11	11	0	4	266	(3/)	266	0
Alaska.....	53	53	0	16	4,754	89.70	4,754	0
Ariz.....	200	200	0	74	9,335	46.68	9,335	0
Calif.....	1,299	1,163	136	625	122,188	94.06	94,973	27,215
Ill.....	338	(2/)	(2/)	134	28,246	83.57	(2/)	(2/)
Ind.....	139	139	0	48	5,446	39.18	5,446	0
Kans.....	95	79	16	40	8,105	85.32	6,794	1,311
Ky.....	27	27	0	12	1,862	(3/)	1,862	0
La.....	581	541	40	242	36,560	62.93	32,244	4,316
Mi.....	712	672	40	235	53,085	74.56	49,565	3,520
Mich.....	56	49	7	21	3,993	71.30	3,303	690
Minn.....	203	176	27	93	19,292	95.03	13,793	5,499
Mo.....	89	89	0	27	2,848	32.00	2,848	0
N. Mex. 4/....	59	59	0	15	3,694	62.61	3,694	0
N. C.....	1	1	0	1	56	(3/)	56	0
Okla.....	337	337	0	147	15,225	45.18	15,225	0
Oreg.....	87	87	0	40	6,114	70.28	6,114	0
Tenn.....	261	229	32	84	17,096	65.50	15,066	2,030
Utah.....	315	315	0	154	15,409	48.92	15,409	0
Va.....	57	57	0	21	2,449	42.96	2,449	0
Wash.....	672	672	0	306	36,199	53.87	36,199	0
W. Va.....	65	60	5	27	4,015	61.77	3,708	307
Wis.....	122	122	0	49	7,387	60.55	7,387	0

1/ Data for this segment of the program, shown separately here, are included in data for the total program. All data subject to revision. 2/ Excludes Illinois breakdown not available. 3/ Average payment not computed on base of fewer than 50 children. 4/ Data for May; June data not received.

Table 11. General assistance: Recipients and payments to recipients, by State, June 1965 1/

/Excludes vendor payments for medical care and cases receiving only such payments/

State	Number of--		Payments to recipients			Percentage change from--			
				Average per--		May 1965 in--		June 1964 in--	
	Cases	Recipients	Total amount	Case	Recipient	Number of recipients	Amount	Number of recipients	Amount
Total 2/	317,000	663,000	$20,784,000	$65.54	$31.33	-4.2	-2.8	-6.3	-1.3
Ala.	64	64	850	13.28	13.28	(3/)	(3/)	(3/)	(3/)
Alaska	177	660	10,819	61.12	16.39	0	0	+20.9	+9.1
Ariz.	2,098	5,024	116,401	55.48	23.17	-4.8	+2.3	+2.2	+1.0
Ark.	284	986	4,255	14.98	4.32	-3.0	+.7	-5.6	-2.1
Calif.	19,805	31,560	1,224,160	61.81	38.79	-2.3	+1.9	-22.9	-13.9
Colo.	1,420	5,028	63,142	44.47	12.56	+.4	-5.8	+15.2	+26.3
Conn.	4/ 4,728	4/ 12,524	4/ 331,494	70.11	26.47	-22.3	-13.1	+32.5	+30.4
Del.	1,484	2,674	82,297	55.46	30.78	-5.3	-1.9	-3.3	+1.6
Dist. of Col.	799	860	60,735	76.01	70.62	+3.2	+.4	+12.1	+17.1
Fla. 5/	8,200	(6/)	249,000	---	---	---	---	---	---
Ga.	2,172	4,853	71,915	33.11	14.82	-4.2	+.4	-3.8	+2.4
Guam 7/	20	20	853	(3/)	(3/)	---	---	---	---
Hawaii	944	1,215	68,876	72.96	56.69	-3.8	-4.0	-13.6	-7.5
Ill.	25,167	51,379	1,940,799	77.12	37.77	-6.3	-5.6	-11.4	-12.6
Iowa 5/	3,600	8,000	131,000	---	---	---	---	---	---
Kans.	2,810	6,338	189,421	67.41	29.89	-.9	+.1	-9.0	+4.4
Ky.	979	2,938	38,119	38.94	12.97	-20.8	-5.9	-28.9	-26.8
La.	8,124	8,966	423,605	52.14	47.25	-1.9	-1.6	+.1	(8/)
Maine	2,480	8,071	108,950	43.93	13.50	-13.3	-17.8	+1.3	+6.3
Md.	7,542	9,220	570,029	75.58	61.83	+8.8	-.2	+29.7	+25.6
Mass.	7,194	15,003	555,513	77.22	37.03	-3.5	+2.1	-1.9	+6.9
Mich.	19,226	55,580	1,459,733	75.92	26.26	-1.5	-2.1	-16.8	-20.4
Minn.	9,343	25,004	693,193	74.19	27.72	-17.5	-15.0	-3.5	-10.2
Miss.	1,243	1,557	18,679	15.03	12.00	-5.5	-2.6	-7.2	-.3
Mo.	9,957	12,744	656,873	65.97	51.54	-3.9	-3.8	+4.4	+3.9
Mont.	1,035	3,086	54,449	52.61	17.64	-18.7	-14.3	-21.9	-8.6
Nev.	352	556	21,648	61.50	38.94	-5.8	+.4	-17.1	+6.4
N. H.	815	2,716	51,581	63.29	18.99	-15.5	-10.1	-7.7	-5.3
N. J. 9/	9,534	29,947	1,175,670	123.31	39.26	-6.5	-2.0	-.1	+3.3
N. Mex.	260	523	12,130	46.65	23.19	-4.0	+3.0	-38.4	-35.5
N. Y. 10/	51,709	109,545	4,386,766	84.84	40.05	(11/)	+.7	+16.6	+25.0
N. C.	1,520	4,012	39,403	25.92	9.82	-3.4	+5.3	+15.5	+61.6
N. Dak.	308	1,190	17,843	57.93	14.99	-28.3	-19.3	-6.8	-12.9
Ohio	24,708	74,458	1,643,417	66.51	22.07	-3.5	-3.8	-22.2	-18.1
Okla.	8,807	(6/)	123,580	14.03	---	---	+27.9	---	-14.0
Oreg.	4,622	(6/)	259,085	56.05	---	---	-3.0	---	+15.4
Pa.	34,528	41,779	2,212,291	64.07	52.95	-2.2	-3.5	-7.4	-2.5
P. R.	2,506	2,506	23,881	9.53	9.53	+84.4	+114.4	+9.8	+11.7
R. I.	2,784	6,544	169,903	61.03	25.96	-2.9	+.9	+1.3	+8.5
S. C 12/	1,249	1,457	39,883	31.93	27.37	---	---	---	---
S. Dak.	366	1,269	12,063	32.96	9.51	-39.7	-42.6	-4.2	-.7
Tenn.	1,984	3,259	52,862	26.64	16.22	-6.3	+.6	-25.5	+56.1
Tex. 13/	8,600	(6/)	240,000	---	---	---	---	---	---
Utah	1,692	4,794	122,981	72.68	25.65	-1.5	+7.5	+9.9	+12.2
Vt. 13/	1,300	(6/)	40,000	---	---	---	---	---	---
V. I.	205	216	7,602	37.08	35.19	0	-1.2	+20.0	+43.1
Va.	2,671	6,600	132,690	49.68	20.10	-1.4	+3.1	+10.8	+16.9
Wash.	8,382	12,405	569,463	67.94	45.91	+.8	-2.1	-4.1	+7.8
W. Va.	1,768	2,693	63,460	35.89	23.56	+1.3	+2.7	+12.4	+16.1
Wis.	6,195	18,590	544,415	87.88	29.29	-8.3	-5.7	-17.9	-21.3
Wyo.	342	1,155	24,520	71.70	21.23	-18.0	-8.7	+.3	+4.3

1/ All data subject to revision. 2/ Partly estimated; does not represent sum of State figures because totals exclude for New Jersey an estimated number of cases and persons receiving only medical care, hospitalization, and/or burial and payments for such services; recipient count also includes an estimate for States not reporting such data. Excludes Idaho, Indiana, and Nebraska; data not available. 3/ Average payment not computed on base of fewer than 50 recipients; percentage change on fewer than 100 recipients. 4/ About 13 percent of this total is estimated. 5/ Partly estimated. 6/ Data not available. 7/ Data for March; June data not received. 8/ Increase of less than 0.05 percent. 9/ Includes an unknown number of cases and persons receiving only medical care, hospitalization, and/or burial, and total payments for such services. 10/ Includes and unknown number of cases and persons receiving only medical care. 11/ Decrease of less than 0.05 percent. 12/ Data for May; June data not received. 13/ Estimated on basis of reports from sample of local jurisdiction.

Table 12. Amount of vendor payments for medical care for recipients of public assistance, by program and State, June 1965 1/

State	Old-age assistance	Medical assistance for the aged	Aid to the blind	Aid to the permanently and totally disabled	Aid to families with dependent children	General assistance 1/
Total	$38,777,869	$50,363,164	$1,131,343	$12,334,169	$14,053,322	$10,052,000
Ala	1,114,103	81,301	3,926	66,283	699	26
Alaska 2/	37,947	(3/)	---	20,720	82	69,794
Ariz	73,660	(3/)	---	---	---	---
Ark	785,067	190,079	20,504	223,133	54,892	34,230
Calif	3,326,880	9,852,195	303,490	1,372,522	1,341,292	167,836
Colo	759,396	4/ 972,211	4,133	102,835	116,751	95,957
Conn	256,867	4/ 1,445,219	22,482	394,700	666,183	---
Del	27,975	24,915	150	---	---	---
D. C	64,509	388,300	878	38,141	1,477	485
Fla. 2/	1,173,917	278,501	20,764	220,638	57,357	---
Ga	1,049,579	(3/)	15,318	190,914	---	---
Guam	(5/)	(5/)	---	---	160	---
Hawaii 2/	13,579	140,175	1,795	75,338	51,697	20,815
Idaho	53,400	343,123	85	24,882	---	---
Ill. 2/	2,725,100	532,425	81,260	1,024,998	1,781,449	852,998
Ind	963,420	74,537	47,020	140,226	281,989	---
Iowa	1,013,497	569,010	12,000	---	196,487	6/ 320,000
Kans. 2/	575,796	4/ 465,010	11,026	126,668	255,720	174,508
Ky. 2/	873,594	353,444	29,391	184,742	321,725	---
La	2,355,116	98,501	7,179	115,141	30,762	4,259
Maine 2/	336,505	156,166	3,762	46,371	25,985	95,765
Md. 2/	107,886	7/ 593,589	3,920	145,433	---	678
Mass	1,196,044	4/ 5,508,765	16,478	1,125,783	601,991	219,647
Mich	1,140,881	2,763,920	22,539	355,281	334,446	560,689
Minn	1,165,945	4/ 2,801,091	47,547	50,670	510,079	393,358
Miss	262,010	(3/)	3,165	---	---	---
Mo	1,190,058	(3/)	---	77,606	55,305	24,919
Mont	5,787	(3/)	1,122	867	786	453,919
Nebr	713,091	4/ 114,177	31,280	141,152	66,296	---
Nev	60,028	(3/)	3,831	(3/)	10,556	162,007
N. H	97,552	117,413	5,297	24,563	34,017	---
N. J	337,747	4/ 1,228,748	11,371	270,070	342,630	328,294
N. Mex. 2/ 8/	195,102	(3/)	6,822	76,734	103,411	5,600
N. Y. 2/	1,222,372	4/ 12,476,646	99,952	2,247,277	3,079,310	324,452
N. C	408,694	394,276	21,589	416,843	317,959	132,615
N. Dak. 2/	156,735	4/ 331,844	1,891	119,458	67,809	23,229
Ohio	2,364,593	(3/)	42,578	283,554	547,343	1,042,351
Okla. 2/	1,629,126	159,845	32,126	290,367	74,028	---
Oreg	134,595	610,319	4,953	173,737	130,587	76,252
Pa	686,306	2,812,256	72,270	420,716	1,062,293	1,428,191
P. R. 2/	7/ 27,119	7/ 102,395	130	2,053	---	---
R. I. 2/	98,697	496,188	1,855	55,748	121,867	63,979
S. C. 2/	364,187	213,382	18,345	83,698	23,358	13,017
S. Dak	208,560	29,440	---	---	---	101,112
Tenn	630,053	344,953	2,884	37,982	49,112	---
Tex	2,904,387	(3/)	---	---	---	---
Utah	65,955	244,023	3,239	141,412	104,013	1,921
Vt. 2/	269,571	27,660	2,256	34,113	---	---
V. I	353	6,888	3	56	148	200
Va	280,487	251,127	13,939	100,229	58,347	22,128
Wash	759,772	1,520,885	17,267	656,847	435,181	176,170
W. Va	208,205	291,252	11,673	74,892	409,530	68,677
Wis	2,266,925	925,879	44,676	547,856	317,101	177,189
Wyo	39,139	31,091	1,182	10,920	11,112	38,515

1/ Data incomplete. Some States do not report these data and for some the data represent only partial reporting. The total includes an estimated amount for these States. 2/ Except for aid to families with dependent children and general assistance, data represent payments for recipients of the specified type of assistance under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 3/ No program in operation. 4/ Includes money payments not subject to Federal participation as follows: $26,231, in Colorado, $22, in Connecticut, $11,986, in Kansas, $97,083 in Massachusetts, $35,698 in Minnesota, $48, in Nebraska, $8,382, in New Jersey, $50,182, in New York, and $2,847, in North Dakota. 5/ Data not reported. 6/ Partly estimated 7/ Estimated. 8/ Data for May; June data not received.

Table 13. Average payment per recipient for all assistance, for money payments, and for vendor payments for medical care, by program and State, June 1965 1/

State	Old-age assistance			Medical assistance for the aged	Aid to the blind			Aid to the permanently and totally disabled			Aid to families with dependent children (per recipient)		
	All assistance	Money payments to recipients	Vendor payments for medical care		All assistance	Money payments to recipients	Vendor payments for medical care	All assistance	Money payments to recipients	Vendor payments for medical care	All assistance	Money payments to recipients	Vendor payments for medical care
Total	$80.36	$59.33	$21.03	$190.48	$87.88	$76.01	$11.87	$84.65	$62.45	$22.21	$33.83	$30.66	$3.17
Ala.	67.13	57.20	9.93	316.35	68.78	66.65	2.13	46.34	41.90	4.43	11.81	11.80	.01
Alaska 2/	98.38	70.72	27.66	(3/)	83.89	83.89	---	167.04	71.56	95.48	34.86	34.85	.02
Ariz.	63.49	57.96	5.53	(3/)	71.67	71.67	---	67.30	67.30	---	28.71	28.71	---
Ark.	63.86	50.72	13.14	61.32	70.62	60.06	10.56	61.87	38.68	23.19	16.88	15.13	1.75
Calif.	109.49	97.40	12.09	310.13	145.15	120.67	24.48	117.68	98.91	18.77	43.07	40.70	2.37
Colo.	97.38	80.09	17.29	171.44	87.41	70.81	16.60	79.57	62.84	16.73	37.85	35.20	2.65
Conn.	100.02	61.64	38.37	194.75	135.01	62.25	72.76	90.59	44.01	46.58	48.37	37.19	11.18
Del.	72.17	52.37	19.80	191.65	82.60	82.12	.48	76.55	76.55	---	28.51	28.51	---
Dist. of Col.	91.40	64.04	27.36	472.38	78.42	74.11	4.30	83.12	71.65	11.48	32.65	32.58	.07
Fla. 2/	65.09	49.27	15.82	335.95	68.01	59.99	8.02	68.52	56.06	12.46	15.68	15.15	.53
Ga.	58.47	47.08	11.38	(3/)	60.69	55.88	4.80	61.49	54.43	7.06	22.14	22.14	---
Guam 4/	33.58	33.58	---	(5/)	(6/)	(6/)	---	(6/)	(6/)	---	16.12	15.89	.24
Hawaii 2/	71.78	60.42	11.35	259.58	95.62	71.03	24.59	117.39	55.43	61.96	35.25	31.46	3.79
Idaho	73.58	60.81	12.77	138.75	71.93	71.29	.64	57.38	49.31	8.07	38.77	38.77	---
Ill. 2/	95.15	45.23	49.93	362.93	96.62	62.65	33.97	101.43	67.13	34.31	44.93	38.13	6.80
Ind.	86.95	44.26	42.69	182.24	88.69	61.94	26.75	135.66	48.56	87.10	29.66	23.90	5.75
Iowa	95.13	57.30	37.84	110.08	102.66	92.05	10.61	83.36	83.36	---	38.92	34.62	4.30
Kans. 2/	97.44	70.52	26.92	158.54	101.06	79.14	21.92	114.65	89.82	24.83	38.77	32.09	6.68
Ky. 2/	64.01	49.31	14.70	28.17	74.59	62.85	11.74	78.14	62.03	16.11	25.55	21.72	3.83
La.	84.93	66.96	17.96	159.13	81.34	78.74	2.61	58.75	52.89	5.86	23.08	22.79	.29
Maine 2/	83.52	52.53	30.99	261.58	86.46	73.96	12.50	90.37	69.87	20.49	28.85	27.48	1.37
Md. 2/	74.01	63.26	10.75	(7/)	80.99	70.99	10.00	86.55	68.30	18.26	33.77	33.77	---
Mass.	93.00	69.91	23.09	180.91	137.18	129.81	7.37	151.59	66.66	84.93	47.71	41.61	6.10
Mich.	104.47	81.02	23.44	428.25	94.27	80.75	13.52	115.02	85.37	29.66	36.34	34.30	2.04
Minn.	89.71	52.86	36.85	194.83	112.22	67.19	45.03	61.34	48.41	12.93	52.30	42.70	9.60
Miss.	41.17	37.60	3.57	(3/)	45.89	44.67	1.23	43.90	43.90	---	9.13	9.13	---
Mo.	69.82	58.09	11.73	(3/)	75.00	75.00	---	72.75	67.69	5.06	24.31	23.80	.51
Mont.	72.39	71.27	1.12	(3/)	88.02	83.37	4.66	79.13	78.50	.63	36.49	36.38	.10
Nebr.	97.55	40.17	57.38	344.95	105.82	55.53	50.29	97.95	46.15	51.80	31.79	27.92	3.87
Nev.	87.41	64.93	22.48	(3/)	118.92	94.83	24.09	(3/)	(3/)	(3/)	31.43	29.45	1.98
N. H.	101.85	79.55	22.30	51.95	108.21	87.83	20.37	118.50	79.07	39.43	43.75	36.54	7.21
N. J.	88.82	64.59	24.23	227.46	88.67	76.34	12.33	101.43	70.76	30.67	50.32	47.19	3.12
N. Mex. 2/ 8/	77.61	58.46	19.14	(3/)	94.00	74.34	19.66	90.24	70.40	19.84	33.02	29.52	3.50
N. Y. 2/	94.00	72.57	21.43	339.02	116.67	85.29	31.38	134.72	72.70	62.02	47.45	41.75	5.70
N. C.	62.96	53.41	9.55	186.86	70.19	65.81	4.38	77.19	58.95	18.24	25.44	22.64	2.80
N. Dak. 2/	97.17	66.31	30.86	232.71	92.80	69.46	23.35	133.34	64.37	68.97	45.60	37.51	8.09
Ohio	95.06	65.99	29.08	(3/)	83.02	69.96	13.06	78.61	64.25	14.36	31.23	28.43	2.80
Okla. 2/	96.25	76.46	19.79	141.58	122.26	102.41	19.86	112.23	92.46	19.77	33.22	32.23	.99
Oreg.	70.79	57.49	13.31	147.99	89.57	79.01	10.56	68.27	47.11	21.16	38.83	34.81	4.01
Pa.	78.59	63.65	14.95	244.74	75.84	71.72	4.12	77.54	57.46	20.08	31.32	27.65	3.67
P. R. 2/	9.51	8.60	.91	(7/)	8.80	8.70	.09	9.16	9.06	.10	4.13	4.13	---
R. I. 2/	96.24	79.12	17.12	56.84	94.13	76.63	17.50	96.14	76.91	19.23	41.69	36.52	5.17
S. C. 8/	54.36	39.98	14.37	170.43	64.18	54.35	9.83	54.53	45.23	9.30	15.97	15.17	.80
S. Dak.	100.42	70.42	30.00	47.03	68.46	68.46	---	70.18	70.18	---	32.15	32.15	---
Tenn.	59.22	45.12	14.10	32.55	55.84	54.44	1.40	55.11	52.31	2.80	22.46	21.83	.63
Tex.	70.14	57.56	12.58	(3/)	69.66	69.66	---	57.13	57.13	---	18.71	18.71	---
Utah	70.04	56.10	13.94	98.00	75.42	56.02	19.40	67.10	38.61	28.49	32.15	27.69	4.46
Vt. 2/	97.50	47.19	50.32	219.52	78.78	59.98	18.80	86.86	60.25	26.61	29.69	29.69	---
V. I.	38.42	37.64	.78	48.51	(6/)	(6/)	(6/)	38.59	37.59	1.00	20.07	19.93	.14
Va.	67.24	45.88	21.35	70.76	72.51	60.29	12.23	71.01	56.50	14.51	25.27	24.00	1.27
Wash.	84.47	61.04	23.43	146.38	93.01	67.24	25.77	65.84	30.11	35.73	35.16	29.29	5.86
W. Va.	54.24	39.40	14.85	26.30	57.63	42.67	14.97	53.27	40.39	12.88	26.71	23.08	3.63
Wis.	111.52	30.71	80.81	132.86	107.48	51.15	56.34	122.99	37.23	85.76	47.07	39.92	7.15
Wyo.	84.46	68.24	16.22	(6/)	95.04	73.93	21.11	83.34	67.85	15.49	38.79	35.88	2.92

1/ Averages based on cases receiving money payments, vendor payments for medical care, or both. Money payments may also include small amounts for assistance in kind and vendor payments for other than medical care. Averages for general assistance not computed because of difference among States in policy or practice regarding use of general assistance funds to pay medical bills for recipients of the special types of public assistance. 2/ Except for aid to families with dependent children, data for each program represent average payments for recipients of the specified type of assistance under program for aid to the aged, blind, or disabled or for such aid and medical assistance for the aged. 3/ No program in operation. 4/ Data for March; June data not received. 5/ Data not reported. 6/ Average payment not computed on base of fewer than 50 recipients. 7/ Estimated. 8/ Data for May; June data not received.

Old-age, survivors, and disability insurance benefits, summary data, June 1965

CURRENT MONTH DATA

Type of benefit	Benefits awarded in month		Benefits awarded in current-payment status, end of month			Amount of benefits paid 1/ in month (in thousands)
	Number	Average amount	Number	Monthly rate (in thousands)	Average amount	
Total, OASI and DI	346,166	---	---	---	---	$1,429,273
Total, OASI	299,093	---	---	---	---	1,302,972
Monthly benefits, OASI and DI	244,311	---	20,156,883	$1,357,337	---	1,408,257
Monthly benefits, OASI	197,238	---	18,508,707	1,250,627	---	1,281,956
Monthly benefits, DI	47,073	---	1,648,176	106,711	---	126,301
Old-age (retired-worker)	99,667	$82.50	10,842,620	845,479	$77.98	859,049
Disability (disabled-worker)	23,947	93.75	943,672	86,011	91.14	100,765
Wife's or husband's (OASI and DI)	34,580	39.11	2,787,818	111,085	39.85	116,077
Wife's or husband's (OASI)	28,266	40.24	2,601,190	105,088	40.40	108,401
Wife's or husband's (DI)	6,314	34.07	186,628	5,997	32.14	7,676
Widow's or widower's	24,691	74.23	2,227,506	152,270	68.36	157,992
Parent's	297	80.28	35,799	2,523	70.47	2,770
Child's (OASI and DI)	51,587	---	2,847,521	131,992	---	141,349
Child's (OASI--total)	34,775	---	2,329,645	117,290	---	123,489
Child's (OASI--life) 2/	9,042	28.70	429,278	12,133	28.26	12,806
Child's (OASI--survivor) 2/	25,733	53.47	1,900,367	105,157	55.34	110,683
Child's (DI)	16,812	28.31	517,876	14,702	28.39	17,860
Mother's	9,542	61.64	471,947	27,977	59.28	30,255
Lump sum death payments	101,855	3/218.54	---	---	---	21,016

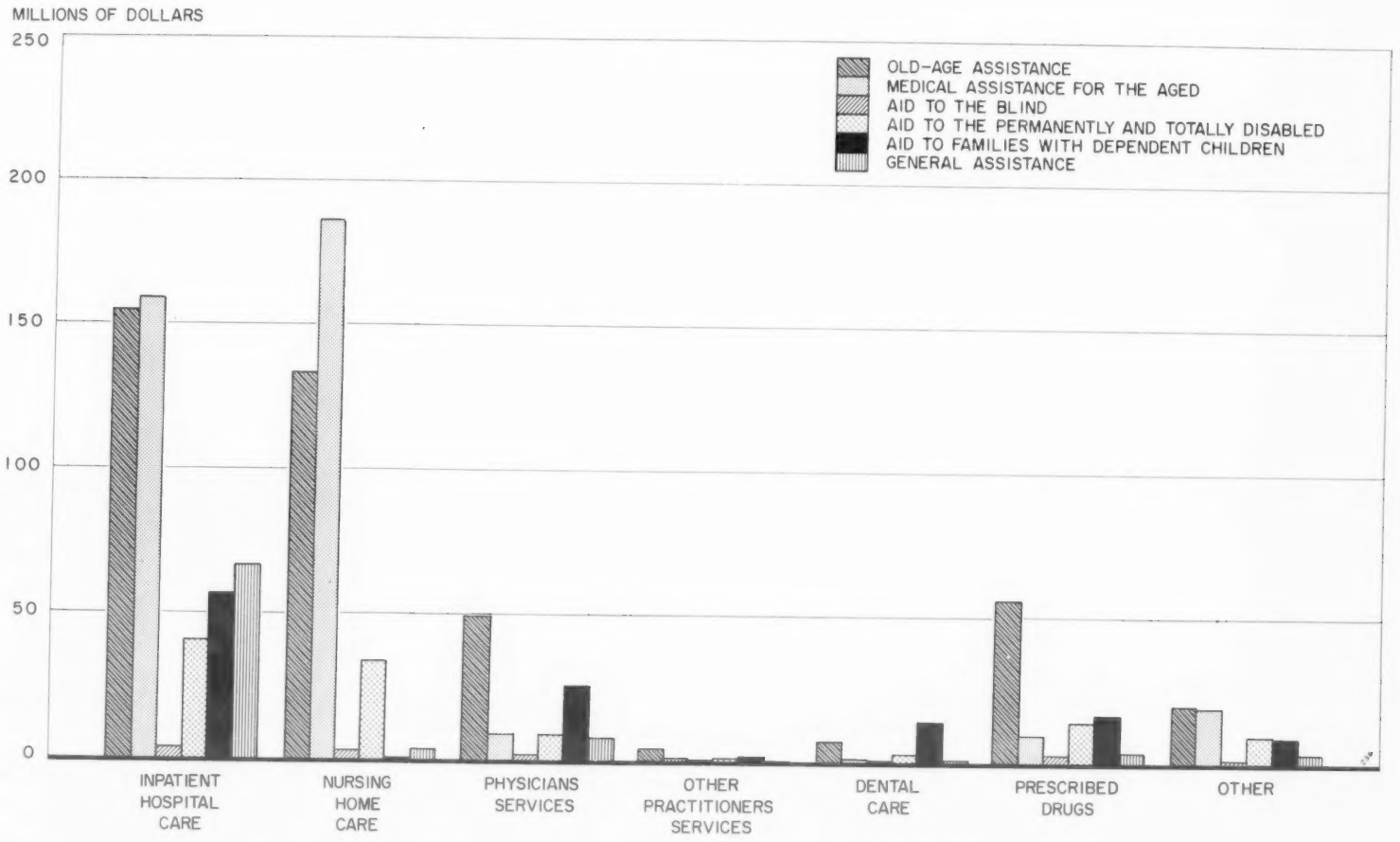
COMPARATIVE DATA

Item	June 1965	May 1965	June 1964
Number of benefits in current-payment status, end of month:			
Total, OASI and DI	20,156,883	20,074,067	19,470,319
Total, OASI	18,508,707	18,442,360	17,954,085
Total, DI	1,648,176	1,631,707	1,516,234
Amount of benefits paid (in thousands):			
Total, OASI and DI	$1,429,273	$1,413,338	$1,355,517
Total, OASI	1,302,972	1,291,719	1,244,839
Total, DI	126,301	121,619	110,678
Number of old-age (retired-worker) benefits:			
Awarded	99,667	86,592	89,036
In current-payment status, end of month	10,842,620	10,800,817	10,481,752
Average old-age (retired-worker) benefit:			
Awarded	$82.50	$80.89	$79.93
In current-payment status, end of month	77.98	77.93	77.29
Number of disability insurance (disabled-worker) benefits:			
Awarded	23,947	21,410	20,242
In current-payment status, end of month	943,672	933,356	861,930
Average disability insurance (disabled-worker) benefit:			
Awarded	$93.75	$93.66	$95.35
In current-payment status, end of month	91.14	91.13	90.84
Number of persons aged 62 and over receiving monthly benefits, end of month (OASI and DI) 4/	15,766,000	15,707,000	15,226,000
Number of persons aged 65 and over receiving monthly benefits, end of month (OASI and DI) 4/	13,868,000	13,816,000	13,376,000
Assets of trust funds, end of month (in millions):			
OASI	$20,180	$20,384	$19,699
DI	2,007	2,027	2,264

1/ Exceeds monthly amount of benefits in current-payment status because initial payments include amounts payable for prior months. Distribution by type of monthly benefit estimated.
2/ Distribution by type of claim for OASI child's benefits estimated.
3/ Average lump-sum per worker; 96,166 deceased workers represented in the current month's lump-sum awards.
4/ Numbers estimated to the nearest thousand.

Source: Division of the Actuary, Social Security Administration.

VENDOR PAYMENTS FOR MEDICAL CARE, BY PROGRAM AND TYPE OF SERVICE, FISCAL YEAR 1964



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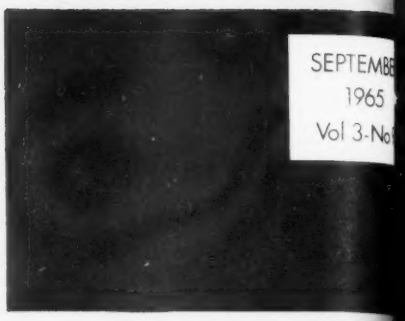

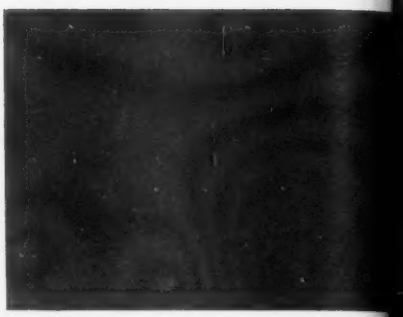

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